Preliminary MITA State Self-Assessment

State of Colorado
Department of Health Care Policy and Financing

October 12, 2007

Executive Summary

The initial Medicaid Information Technology Architecture (MITA) State Self-Assessment completed by Public Knowledge in collaboration with the Colorado Department of Health Care Policy and Financing resulted in a State Self-Assessment Profile. This profile can be used by the Department to communicate their business process baseline to CMS when requesting enhanced funding for upcoming initiatives.

This report provides the results of the high-level initial assessment of the State's business processes against those provided in the MITA Framework 2.0 released by CMS in March 2006 and focuses only on a review of the Business Architecture as presented in the Framework. This initial State Self-Assessment was intended to result in an assessment profile indicating the State's current business capability level ("As Is") for each process and the targeted business capability ("To Be") for those processes for which Colorado has planned initiatives, system change requests, or legislation to move the state to a higher level in the capability maturity model for MITA.

At the request of the Department, this initial assessment did not follow every step of a MITA State Self-Assessment as outlined by CMS in the MITA Framework 2.0, Part I, Chapter 6 State Self-Assessment or the recently released MITA Framework 2.0, Part I, Appendix E MITA State Self-Assessments Details. The assessment bypassed some steps by using existing materials. For example the Medicaid enterprise's goals and objectives were not considered when determining "To Be" capability levels. In addition, the results of the assessment do not include actual Colorado business process definition, mapping, or documentation for the current or future business processes, but document only the business capability level of each process as reached through consensus with Department subject matter experts. The agency may revisit these areas in more depth as part of future projects.

The rest of this document is organized as described below:

Purpose of Colorado's Assessment

As of April 2007 CMS is requesting that a State Self-Assessment be attached to any request for enhanced federal funding. In response to the encouragement from CMS to conduct an assessment of the capability level of Medicaid business processes as outlined in the MITA Framework version 2.0, the Department of Health Care Policy and Financing's Information Technology Division requested Public Knowledge, LLC assist the Department in an initial assessment as part of the MMIS Re-procurement Project.

MITA Overview

The MITA is an initiative to establish national guidelines for technologies and processes that can enable improved program administration for state Medicaid enterprises. MITA is intended to foster nationally integrated business and information technology transformation.

This section discusses the mission of the MITA and its goals and objectives. In addition, the overview provides an explanation of the three architectures of MITA and, in particular, the State Self-Assessment.

Assessment Approach and Process

The Assessment Approach and Process section describes the high-level evaluation that was conducted of the Department's business process capabilities in relation to those processes defined in the MITA Framework 2.0. The Colorado Department of Health Care Policy and Financing desired to complete a high-level assessment to meet CMS' requirement that a State Self-Assessment Profile be attached to any Advance Planning Document (APD) requesting enhanced federal financing of an MMIS enhancement or procurement. In addition this section presents the State Self-Assessment process recommended by CMS in Part I, Chapter 6 of the MITA Assessment Framework 2.0.

State Self-Assessment Profile

The State Self-Assessment Profile section explains what information is included in the profile. Since CMS distributed new materials regarding the profile prior to the completion of this report, the differences between the original proposed profile and the CMS version are also explained.

The original proposed State Self-Assessment Profile includes columns for each "As Is" and "To Be" business capability level designation and the rationale for the level designation captured. The rationale was included to provide a picture of the information used to develop the baseline profile. CMS' State Self-Assessment guidance for the profile was not distributed to the states until after Colorado's assessment meetings were complete. Once CMS provided guidance for the format of the profile in mid-August at the 2007 MMIS Conference, Public Knowledge recommended that both the original Public Knowledge proposed format and the CMS format for the profile be included in the final document.

Business Area Assessment Summaries

The Capability Level for each Business Process Area is summarized in this section. Capability levels are described in the MITA Framework 2.0 as follows:

- Level 1 – mostly manual, uncoordinated, staff intensive
- Level 2 – moving to more electronic, more coordination within the agency, less staff intensive
- Level 3 – using MITA standard interfaces (these interfaces have not been developed yet), increased coordination with other state agencies
- Level 4 – highly electronic, sharing data regionally with other states, relies on technology not readily available
- Level 5 – all electronic, sharing data nationally with all states and federal agencies, relies on technology not yet on the market

The levels are intended to communicate the capability of the business process in relation to the MITA. A couple of guidelines were considered in assigning the capability level for each State business process.

1. It is expected that all states completing a State Self-Assessment will determine their "As Is" business processes at a Level 1 or Level 2 since, in most cases, the technology to justify a Level 3, 4 or 5 is not readily available. For example, one Level 3 criteria mentioned in most of the business capability matrices states, "MITA standard interfaces are used…" These MITA standard interfaces have not been defined yet.
2. The business process must meet all criteria listed for the capability level in the Business Capability Matrix for the State to assign a particular capability level.

A summary business capability level, along with findings and recommendations are provided for each of the MITA Business Process Model Areas assessed during Colorado's MITA State Self-Assessment. The recommendations provided represent solutions that will help the State move closer to the next level of business capability. In most cases, the State will have to implement more solutions than those identified to meet all the criteria to have a business process be considered at the next level of capability.

Member Management - Level 1 (mostly manual, uncoordinated, staff intensive)

The MITA's Member Management business processes are:

- Determine Eligibility,
- Enroll Member,
- Disenroll Member,
- Manage Member Information,
- Inquire Member Eligibility,
- Perform Population and Member Outreach,
- Manage Applicant and Member Communication, and
- Manage Member Grievance and Appeal.

The Client Services section of the Department is responsible for these processes in Colorado. Two of the processes (disenroll member and manage member grievance and appeal) were not evaluated because business capability levels are not defined in the framework.

Finding(s): Staff designated four of the six evaluated processes as Level 1. The Manage Member Information process would have been a Level 2 except the State pays capitated premiums on a monthly basis rather than a daily basis. It is unclear if the system can support the calculation of capitated premiums on a daily basis versus a monthly basis if the State's policy was changed to allow this functionality. The other three Level 1 business processes (enroll member, perform population and member outreach, and manage applicant and member communication) are mainly manual, require more staff resources, and lack coordination among programs. The remaining two business processes evaluated (determine eligibility and inquire member eligibility) were designated as Level 2 because they utilize standard transactions or rules based engines resulting in more consistent responses and require little or no staff intervention.

Recommendation(s): First, the State should determine if the system could support calculation of the capitated premium payment on a daily basis rather than the monthly basis and then determine the impact of changing the policy to support this change. If the State is able to move to a daily premium capitation policy then the Manage Member Information business process could move to a Level 2 designation.

The criteria in the business process matrices for the Member Management area indicate a movement to more coordination and consistency in messages and responses. As such, the State should leverage functionality through their existing Automated Voice Response System (AVRS) and Electronic Data Interchanges (EDI) tools to promote consistent responses to client requests for information regarding benefits, programs, and providers. In addition, the State should consider the integration of an area within the web portal targeted at clients. The client web portal could provide standard information about benefits, programs and providers. In the past, Colorado has considered making kiosks available at community access points throughout the State. These kiosks are another tool the State could use to provide standard messages to clients. The success of these automated tools will require the State to coordinate development of messages responding to frequently asked questions, marketing materials, benefit and program materials. The integration of client functionality in the AVRS, EDI and web portal and availability of kiosks will assist the State in moving closer to a Level 2 designation in three of the business processes.

Provider Management - Level 1 (mostly manual, uncoordinated, staff intensive)

The MITA's Provider Management business processes are:

- Enroll Provider,
- Disenroll Provider,
- Manage Provider Information,
- Inquire Provider Information,
- Manage Provider Communication,
- Manage Provider Grievance and Appeal, and
- Perform Provider Outreach.

The Provider Services section of the Department is responsible for these processes in Colorado. One of the processes (disenroll provider) was not evaluated because business capability levels are not defined in the framework.

Finding(s): Colorado's Provider Management business processes meet many of the criteria to be a Level 2 (moving to more electronic, more coordination within the agency, less staff intensive) but remain a Level 1 because CMS requires that all criteria be met in order to designate a process at a certain level. The State has expanded use of electronic means to distribute and collect information from providers over the past few years. The Web Portal gives providers many self-service business processes that previously would have required the provider to call provider services for information such as another provider's contact information. The recently added Specialty Look-up allows providers an easy search function for finding certain types of providers. In addition, Colorado providers have the option to receive program communication (bulletins) through email but ¾ of providers still opt for paper bulletins that are sent out monthly by the Department.

The State does not have any automated business rules in place to ease the burden of enrolling providers. Enrolling providers is a time-intensive, manual process because most of

the information has to be manually verified by staff. In the capture and maintenance of provider data, any use of automated data loads from external sources is still manually verified before it is made available. Other processes that rely heavily on manual processes are the Manage Provider Grievance and Appeal process and Perform Provider Outreach process. Though, provider billing manuals and related documentation are available through the provider services website, the documents are maintained and developed manually and uploaded to the website.

Recommendation(s): In order to move closer to a Level 2 designation for the Manage Provider Grievance and Appeal process, the State should consider accepting reconsiderations electronically to assist in tracking and increase the timeliness in turnaround of these appeals.

The State should also evaluate developing and implementing an online, electronic provider manual that can be viewed and printed by Colorado providers. The electronic manual could eliminate the delay required for IT staff to upload updated documents to the website and would allow inaccuracies to be addressed immediately. The electronic manual would move the State closer to a Level 2 designation for the Perform Provider Outreach process.

Contractor Management - Level 1 (mostly manual, uncoordinated, staff intensive)

The MITA's Contractor Management business processes are:

- Manage Health Services Contract,
- Award Health Services Contract,
- Close-out Health Services Contract,
- Manage Administrative Contract,
- Award Administrative Contract,
- Close-out Administrative Contract,
- Manage Contractor Information,
- Inquire Contractor Information,
- Perform Potential Contractor Outreach,
- Manage Contractor Communication, and
- Support Contractor Grievance and Appeal.

The Contract Administration section of the Department is responsible for these processes in Colorado. Four of the processes (award administrative contract, close-out administrative contract, manage contractor information, and inquire contractor information) were not evaluated because business capability levels are not defined or were not defined appropriately in the framework.

Finding(s): The majority of business processes in this area are manual. Colorado manually receives, reads, and scores proposals for Health Services Contracts. The Department utilizes the BIDS procurement system to announce Request for Proposals but does not allow electronic responses to these requests. The process to close-out a Health Services Contract is also manual based on the termination or transition procedures outlined in the contract. In the case of managing a Health Services Contract, the Department does use electronic means to exchange enrollment files and standardized contractor reporting templates that are submitted to the Department via email. The process still relies on manual processes to gather requirements and develop the RFP for Health Services contracts. In the

case of Administrative Contracts, the contract management is not centralized or consistent, monitoring systems are not established for every contract, and quality and accuracy are responded to on a complaint basis. There has been recent movement to more standardization of processes related to contract management and monitoring including the creation of a Service Level Agreement template so that contractor measurement criteria is the same across contracts. Standards for contract management have been created but have not been proliferated throughout the Department.

In the performance of potential contractor outreach, the outreach is legislative driven rather than triggered by agency-wide processes. Outreach is defined by procurement rules for certain types of contracts and conducted differently by different programs. The Department does not conduct outreach based on electronic health records (EHRs) and electronic clinical data available through registries, electronic prescribing, or socioeconomic indicators. Communication with existing contractors is very standardized and somewhat automated with the MMIS contractor but not with all contractors. Grievances and appeals are handled centrally but paper-based. All contractor grievances and appeals are kept in paper files in order to review the decisions when similar actions are filed in the future.

Recommendation(s): The Department needs to proliferate standards for contract management and monitoring to all those responsible for these activities. The standards are only effective when they are available and in use. The management and monitoring of contracts should be consistent from contract monitor to contract monitor. The Department should consider establishing specific performance measures that are consistently applied to all contracts so it can measure the effectiveness of one contract to the next. In addition, the Department should obtain access to or volunteer to participate in the Contractor Performance Database created by SB228-07. The information available in the database may support the work assigned to contract monitors.

In the future, the Department should scan paper grievance and appeal files into an electronic system. To be most effective the Department should use optical character recognition (OCR) in order to support indexing of the information in the documents. Loading these documents into an electronic data management system would allow staff to search and find related grievances and appeals and view easily how the issues were resolved. Staff would save significant time from having to search through paper files and resolutions would likely be more consistent.

Operations Management - Level 2 (moving to more electronic, more coordination within the agency, less staff intensive)

The Operations Management Business Area of the MITA involves 26 business processes that fall under seven business process sub-areas. The business process sub-areas are:

- Payment and Reporting,
- Claims Encounter Adjudication,
- Capitation and Premium Preparation,
- Payment Information Management,
- Member Payment Management,
- Cost Recoveries, and
- Service Authorization.

The Operations Management section of the Department is responsible for these processes in Colorado. Four of the underlying processes (apply claim attachment, calculate spend down, authorize treatment plan, and authorize referral) were not evaluated because Colorado does not conduct the business process or does not conduct it as defined by the MITA.

Finding(s): In most cases the processes were designated at a Level 1 because the Department relies on non-standard electronic files and transactions as well as paper forms. The HIPAA Electronic Transactions and Code Sets rule required states to start conducting more business using standard transactions. Short timeframes for compliance and limited state budgets forced states to minimally implement standard electronic transactions. Many of the transactions provide for administrative simplification if used to their full potential. Expanding the use of the 837 claims transaction would improve process efficiencies for the prepare COB, manage payment information, manage recoupment, and manage TPL recovery business processes. In addition, the ongoing delay in the final rule for the 275 Claim Attachment effects the improvement of certain business processes. The State is waiting for a final rule to make any changes to it claim attachment business process.

The State relies on the Provider Claim Report to supplement the information available on the HIPAA 835 payment advice transactions. The report provides additional information regarding a provider's claims to support the reconciliation to payment. This report is available electronically through an electronic bulletin board. The Department sees the report as essential because the reject reason codes on the 835 are too generic and do not provide enough information to support reconciliation in most cases.

Several of the State's business processes meet most of the criteria for a Level 3 designation but this level consistently requires the use of MITA standard interfaces. MITA standard interfaces have not been defined yet.

Recommendation(s): In order to move most of its Level 1 designated process to a Level 2 and some Level 2's to Level 3, the Department needs to expand its use of standardized electronic transactions. Using the 278 Authorize Service with automated Prior Authorization business rules the Department would see significant efficiencies in the Authorize Service business process. The Department needs to expand the use of the 837 transactions in conducting coordination of benefits. The Department could save time and effort both for themselves and their providers if they submitted or forwarded claims directly to other payers instead of back to providers.

In relation to Medicare premium payments, the Department needs to continue to follow CMS' lead for process improvement in this area. The states are constrained in Medicare premium payment process improvement by what CMS requires.

Finally, the Department should consider whether or not time and resources could be saved and the process improved by authorizing Treatment Plans rather than requiring that each individual service in a treatment plan have a separate authorization. Authorizing at the plan level may reduce the number of authorization to be reviewed by staff.

Program Management - Level 1 (moving to more electronic, more coordination within the agency, less staff intensive)

The Program Management Business Area of the MITA involves 17 business processes that fall under six business process sub-areas. The business process sub-areas are:

- Benefit Administration,
- Program Administration,

- Budget,
- Accounting,
- Program Quality Management, and
- Program Information.

The Agency Administration and Operations section of the Department is responsible for business processes that fall under the budget and accounting sub-areas and the Program/Policy Management section of the Department is responsible for the business administration, program administration, program quality management, and program information sub-areas. Ten of the 17 processes were not evaluated because business capability levels are not defined in the framework.

Finding(s): Participants reported that most of the processes evaluated in this business process area are manual because they require knowledge and expertise to ask the right questions, to evaluate options or data, and to make policy decisions. In a lot of cases decisions are not based on clinical data but on regulatory requirements and financial impact. Once decisions are made by the Department, changes to the system are communicated through transmittals to the Fiscal Agent including the authorization to load electronic data from CMS or other entities such as First Data Bank.

Other processes that rely on manual processes are related to the management of federal and State funds. Where possible these processes are automated such as the electronic submission of required reporting to CMS even though these reports are manually built prior to transmission. The Generate Financial and Program Analysis/Report process depends on two systems to conduct sufficient analysis to manage the Colorado Medicaid program and related programs. The MARS subsystem of the MMIS does not allow analysis of health needs and outcomes but is crucial for transaction and discrete person vs. person analysis. The DSS provides more flexibility in reporting and analysis. The Department requires both systems to meet 100% of the reporting and analysis needs of the programs.

Recommendation(s): The Department should evaluate the use of a business modeling tool that could automate some of the analysis that is performed manually for the Design Approved Service/Drug Formulary and Develop and Maintain Benefit Package business processes. When using a business modeling tool, the Department can simulate how a change in formulary/benefit package will affect the program before it is actually implemented into the system.

The Department should also determine if the manual process to build certain federal reports (CMS 37 and 64) can be automated. The Department should consider during the next procurement of the MMIS to evaluate eliminating the transmittal processes by procuring or enhancing the MMIS so that State staff can execute some or all of the file updates and benefit package updates and creations.

Business Relationship Management – Not Assessed

The MITA's Business Relationship Management business processes are establish business relationship, manage business relationship, manage business relationship communication, and terminate business relationship. The MITA Framework version 2.0 does not contain a business capability matrix for any of these processes so none of these processes were evaluated during this assessment.

Program Integrity Management – Not Assessed

The MITA's Program Integrity Management business processes are identify candidate case and manage case. The MITA Framework version 2.0 does not contain a business capability matrix for either of these processes so none of these processes were evaluated during this assessment.

Care Management – Not Assessed

The MITA's Care Management business processes are manage Medicaid population health, establish case, manage case, and manage registry. The MITA Framework version 2.0 does not contain a business capability matrix for any of these processes so none of these processes were evaluated during this assessment.

Considerations for the Future

States have been consistently looking for and working on opportunities to streamline business processes in an effort to become more efficient. The MITA initiative and its State Self-Assessment process may allow the State to identify additional opportunities for business process improvement and savings through the sharing of best practices among states.

This high-level evaluation and determination of each business process' "As Is" capability is the first step in a multiple step process to bring the Department's Medicaid architecture into alignment with the MITA. The State needs to plan and perform the following activities:

1. **Review Assessment Results with Policy staff.** The Department of Health Care Policy and Financing, IT Division took the opportunity at the end of the MMIS Re-procurement Project to conduct a high-level State Self-Assessment. The Division identified IT staff and some business staff to participate in the assessment sessions. It became apparent through the assessment sessions that additional program and policy staff would have added significant value to the identification of the capability level of each business process. In order to make certain that all viewpoints of each business process are represented in the results of the assessment, the Department should review the "As Is" results of the assessment with policy and program staff and make necessary revisions to the State Self-Assessment Profile.

   In addition, the Department should consider taking this opportunity with IT, policy and program staff to document and map its business processes that it uses to manage and deliver Medicaid and related program services to its clients. A significant amount of business knowledge resides in individual staff's heads and is not documented formally anywhere. Since, knowledge transfer is important as staff retire or move to other positions, this business process documentation assists new or reassigned staff to perform their responsibilities.

2. **Document "To Be" Capability for Each Business Process.** The MITA State Self-Assessment is an opportunity for Colorado to develop a vision of the Department's Medicaid Enterprise. This strategic vision should include documenting goals and

objectives of the organization and the development of outcome measures to determine how well the Department is achieving its goals and objectives over time. Once the Department's management documents a strategic vision for the Medicaid program, management can designate a "To Be" capability for each business process that aligns with the Medicaid strategic vision.

3. **Develop MITA Transition Plan.** Following the designation of the "To Be" capability for each business process, the Department will need to develop a plan to take action to move from one capability level to the next. The Department's MITA Transition Plan should prioritize business process and system improvement activities that focus on those opportunities that bring the greatest return for the Department. These returns should be measured against the performance outcomes established by management during strategic planning. Measures could include staff number, time, and financial resources. This plan will provide guidance to those responsible for transition in executing projects that move the Department's Medicaid architecture to a higher capability level in the MITA.

   States will be expected to conduct ongoing reassessment of business processes as enhanced funding is requested from CMS in coming years. As the Department develops its plan for transition to the MITA, it needs to determine and implement efficient processes to reassess business processes in order to update the State Self-Assessment Profile and to address future versions of the framework as they are released over the next 10+ years. Implementing these processes from the beginning will make certain that the Department does not have to expend significant funds or staff time to address the rollout of the Information and Technology Architectures of the MITA.

4. **Monitor the Evolution of the MITA.** The MITA Framework became widely available to states in March 2006 though it contains significant gaps in information. Of the three architectures involved in the MITA, the Business Architecture is the most complete. CMS has encouraged states to move forward with completing a State Self-Assessment even though more than a third of the business processes for which states are determining business capability levels do not have a defined Business Capability Matrix. It is important that the Department monitor CMS activities to refine the MITA Framework over the next 10+ years. CMS approval of enhanced funding will eventually be intertwined with the activities the State is undertaking to align its Medicaid architecture to the MITA.

Public Knowledge appreciates the opportunity to conduct this assessment in collaboration with the Colorado Department of Health Care Policy and Financing and hopes this report assists the Department as it plans for future business process and system enhancements.

Table of Contents

Purpose of Colorado's Assessment

In April 2007, CMS introduced a new national initiative encouraging states to conduct assessments of their Medicaid business process model against the Medicaid Information Technology Architecture (MITA) Business Process Model. The purpose of this assessment was to determine the maturity level of individual business processes. CMS has requested that states attach a State Self-Assessment Profile to any Advance Planning Document (APD). The profile is intended to support the narrative in the APD requesting enhanced federal funding to move business process(s) to a higher level of maturity.

In response to CMS' direction, the Department of Health Care Policy and Financing's (HCPF) IT Division requested that Public Knowledge, LLC conduct an initial, high-level business process assessment as part of the MMIS Re-procurement Project. This assessment focused on identifying the capability level of each business process for which maturity levels are available in the MITA Framework version 2.0. The profiles resulting from the high-level assessment are provided in Appendix A and B of this document. The Department plans to use the profile as an attachment to any APD submitted to CMS until the State can obtain the funding and allocate the resources required to complete a full State Self-Assessment as outlined in the framework.

At the 2007 MMIS Conference CMS released new material, Appendix E – MITA State Self-Assessments Details. The appendix contains information on how to obtain enhanced federal funding to conduct a State Self-Assessment, where to get more information on the State Self-Assessment, information on using the results of an assessment in the procurement process including as part of the APD and the Request for Proposal (RFP). At the time of release of this information, Colorado's assessment meetings had already been completed.

HCPF plans to conduct a complete a full State Self-Assessment as outlined in Part I, Chapter 6 and Part I, Appendix E of the MITA Framework version 2.0. This assessment will include a review of the Department's strategic goals and objectives, definition and documentation of current business processes, mapping of the Department business process model to the MITA Business Process Model, measure current business processes' maturities against the MITA Business Capabilities Matrices, and identification of target capabilities that will move the State from current capabilities to future capabilities.

MITA Overview

The (MITA) is an initiative of the Center for Medicaid and State Operations (CMSO) to establish national guidelines for technologies and processes that can enable improved program administration for state Medicaid enterprises. The MITA is intended to foster nationally integrated business and information technology transformation. The MITA initiative includes a Framework, processes, and planning guidelines for enabling State Medicaid enterprises to meet common objectives within the MITA Framework, while supporting unique local needs.

Subsection 2.1 MITA's Mission and Goals and Objectives

Subsection 2.1.1 MITA Mission

The MITA mission is to establish a national framework of enabling technologies and processes that support improved program administration for the Medicaid enterprise and for stakeholders dedicated to improving healthcare outcomes and administrative procedures for Medicaid beneficiaries.

Subsection 2.1.2 Goals and Objectives

The MITA Framework, process, and planning guidelines are designed to ensure that technology decisions align with Medicaid business needs and achieve business goals. The MITA Team developed the following goals in response to the Medicaid enterprise mission and goals. Through the realization of these goals, MITA will aid States in achieving their Medicaid mission and goals.

Goals of the MITA:

1. Seamless and integrated systems with effective communication.
2. Common Medicaid goals through interoperability and shared standards.
3. Promoting environments that are flexible, adaptable, and can rapidly respond to changes in programs and technology.
4. Promotion of an enterprise view that supports enabling technologies aligned with Medicaid business processes and technologies.
5. Providing timely, accurate, useable, and easily accessible data to support analysis and decision making for healthcare management and program administration.
6. Providing performance measurement for accountability and planning.
7. Coordinating with public health and other partners to integrate health outcomes within the Medicaid community.

Subsection 2.2 MITA's Architectures

The MITA Framework is the primary product of the MITA initiative. It is a consolidation of principles, business and technical models, and guidelines that creates a template for states

to use to develop their individual enterprise architectures. The MITA Framework consists of three parts: Business Architecture, Information Architecture, and Technical Architecture.

Subsection 2.2.1 Business Architecture

The MITA Business Architecture provides the framework for defining a vision for the next decade of improvements in the Medicaid program operations that result in better outcomes for all stakeholders. The Business Architecture contains models of typical Medicaid business processes and describes how these processes can improve over time. A maturity model is used to show how business capabilities can evolve. States will use the Business Architecture to assess their own current business capabilities and determine future targets for improvement.

MITA's initial focus is on "As Is" modeling in order to establish a nation-wide baseline of state Medicaid programs. Initial assessments establish this business process baseline and allow states to identify areas for improvement, states will then be encouraged to use "To Be" modeling at they plan for future enhancements and procurements.

Subsection 2.2.2 Information Architecture

The MITA Information Architecture is a companion of the Business Architecture. Business processes and capabilities are mapped to a Conceptual Data Model and a Logical Data Model. The information requirements of the Medicaid organization can impose change on the business model, and new business process requirements can require new information. The Information Architecture also includes a data management strategy and data standards.

At this time, states are leading in developing their own Information Architecture. The next version of the MITA framework will develop the initial Conceptual Data Model and Logical Data Model by using early adopter State data models and the Health Level 7's (HL7) Reference Information Model. These initial models will be reviewed and adopted as the first data models in the MITA Information Architecture.

Subsection 2.2.3 Technical Architecture

The MITA Technical Architecture provides an IT staff (State or vendor) with guidance and specifics on how to implement the MITA initiative. The MITA Technical Architecture includes business, technical and data access services; application architecture; and technology standards. Collectively these elements define a set of services and standards that states can use to plan and specify their future systems.

Technical functions, technical capabilities, technical services and the Application Architecture are contained in the MITA Framework 2.0 but the Technical Architecture is not sufficiently defined to be assessed for alignment at this time. CMS envisions that teams of states will select various subsets of technical components, refine the activities, and standardize the information exchanges. From this activity will come model business and

technical services that states and vendors will develop. The business community must still decide the requirements for standardized Triggers and Results. The CMS MITA team will continue to support state efforts by serving as a conduit for improvements to MITA models that all states and vendors can access.

Subsection 2.2 State Self-Assessment

Subsection 2.2.1 Purpose

The State Self-Assessment is a tool for states to plan their transitions from current capabilities to future, targeted capabilities. Using the State Self-Assessment, a state reviews its current operations and develops a list of target capabilities that allow it to meet its strategic goals. Target capabilities are those that the State plans to implement to transform its Medicaid enterprise to align with MITA principles.

Subsection 2.2.2 Uses of State Self-Assessment

A State Self-Assessment may be used by a state for a variety of functions. It can be used throughout the life cycle of the state's planned business transformation to monitor progress and outcome compliance with the State Plan. Other uses include:

- Document State Requirements – The State Self-Assessment can be used as a guide for specifying implementation requirements at a lower level of detail.

- Prepare and Review APDs – CMS will ask states to attach their State Self-Assessments to their APDs. The State Self-Assessment will bring consistency and comparability to the APD review process. It is intended to reduce the size (i.e., number of pages) of the APD. States will only have to explain how the enhancement or new system will move targeted business processes from the "As Is" capability to the "To Be" capability.

- Prepare RFPs – RFP requirements should align with the State Self-Assessment. The State Self-Assessment documents gaps seen by the State and the desired business process capabilities the State hopes to achieve in its transition plan. The original State Self-Assessment can be attached to the RFP to show potential contractors the State's business process baseline and targeted improvements.

- Evaluate Proposals – The State Self-Assessment can be built into a state's process for evaluating proposals. The assessment can be mapped to the business process improvements that can be gained by the proposer's solution.

- Negotiate Contracts – The State Self-Assessment can be used during contract negotiations, tying process capability level to cost. As an attachment to a contract, the State Self-Assessment binds a vendor to deliver the levels of capability documented.

- Monitor Design, Development, and Implementation – The State Self-Assessment should be referred to during requirements validation, design, development, testing, and implementation.

- Evaluate and Approve New Solutions – CMS will use a state's assessment as a part of the federal certification review process. The MITA Business Process Model maps easily to the business areas in CMS' new certification review process.

Assessment Approach & Process

This section describes the approach used to conduct the high-level evaluation of the Department's business process capabilities in relation to those processes defined in the MITA Framework 2.0. The Colorado Department of Health Care Policy and Financing desired to complete a high-level assessment to meet the CMS requirement that a State Self-Assessment Profile be attached to any Advance Planning Document (APD) requesting enhanced federal financing of an MMIS enhancement or procurement. The assessment results provide information for the State to use in planning new initiatives such as Medicaid Transformation Grant, Heath Information Technology, and other new legislation. The assessment process did not include setting goals and objectives of the Medicaid agency, documenting "As Is" business processes or visioning sessions to document "To Be" business processes as described in the Framework's approach to the assessment. The Department plans to conduct a full State Self-Assessment in the near future from defining its Medicaid organization's goals and objectives to determining the vision and target business process capabilities of the Colorado Medicaid program for the next 10+ years.

Subsection 3.1 MITA's Approach to State Self-Assessment

The MITA Framework's Part I, Chapter 6 State Self-Assessment outlines a four-step process for completing a State Self-Assessment.

Step 1 – List and Prioritize the State's Goals and Objectives

The State is encouraged to identify and prioritize the Medicaid agency's goals and objectives. These prioritized goals and objectives will be used by assessment participants in making decisions on target business capabilities. CMS recommends that these goals and objectives be defined to a level of detail to support the development of specific outcomes and performance measures.

Step 2 – Define the State's Current Business Model and Map to the MITA Business Process Model

The State maps their business process areas against the areas in the Business Process Model available in the MITA Framework. This mapping may require the State to review the business processes contained in the MITA business process area since the State's vocabulary may differ from the MITA vocabulary. There will be cases where a state may have a business process that is not represented in the MITA Business Process Model. CMS requests that the State include the business process with associated business capability statements for each capability level to the MITA initiative. This is the one means CMS will use to improve the MITA Framework in future versions.

Step 3 – Assess the State's Current Capabilities

The State uses the Business Capabilities Matrix for each process to evaluate and designate a business capability level for the process. This capability level designation becomes the baseline for which future improvements are measured against. For example: "Will this

improvement contribute to the process moving from a level 1 business capability to a level 2 capability?"

Step 4 – Determine the State's Target Capabilities

Using the Business Capabilities Matrix and the Medicaid agency's goals and objectives, assessment participants identify a target capability for the process being evaluated. Target capabilities reflect the State's desired capability level as they progress through transition from their current architecture to the MITA. During the evaluation a state may realize they have no aspirations in relation to the business process that would move the capability level from the baseline. In these cases, no target capability should be designated.

The culmination of the current capabilities and the target capabilities should be documented in a State's Self-Assessment Profile. This profile becomes one basis for planning, prioritizing, and requesting funding for business process and system improvements.

Subsection 3.2 Colorado's Approach to Performing Assessment

The approach to conducting this evaluation of Colorado's Medicaid business processes was developed by Public Knowledge, LLC in coordination with Keith Clay and John Wagner. The purpose of the initial Colorado State Self-Assessment was to meet the need of the Department to document the "As Is" capability level of each Medicaid process and where appropriate "To Be" target capability level with respect to the MITA Framework version 2.0. The target end result was a State Self-Assessment Profile documenting the capability level of each business process conducted by the Colorado Medicaid program for which the Business Capability Matrix was defined in the MITA Framework 2.0. The profile sets the baseline for the Colorado Department of Health Care Policy and Financing to use as a tool for planning future enhancements and procurements.

The approach began with grouping business processes based on the tier system in the MITA Business Process Model presented in MITA Framework version 2.0. The processes outlined in the Business Process Model were grouped into 21 sessions. The assessment meetings were conducted between July 17 and August 22, 2007. Fifteen (15) MITA Assessment sessions were held, each addressing a specific grouping of related business process based on the tier system in the MITA Business Process Model. Six (6) of the groupings originally identified were not scheduled because the MITA Framework 2.0 did not provide definitions of capability levels for the processes in these groupings. For example, from the MITA Business Process Model, there were no business capability matrixes for Care Management or Business Relationship Management.

During each session, the business process description from the MITA Framework 2.0, Part I, Appendix C for each business process was reviewed with participants. Public Knowledge documented where Colorado's process varied from the MITA description. Public Knowledge then captured information regarding any known initiatives, legislation, or other potential impacts to the process. In addition, participants provided information regarding interfaces with other systems, or external systems (i.e., spreadsheets, databases, etc.) that are

used to support Colorado's business process. All this information was used to facilitate the discussion regarding the business capability matrix to determine the "As Is" capability level for the process. The information also supported the recommended "To Be" target capability documented in the profile. Public Knowledge recommended a target capability level for business processes where there appeared to be some initiative or legislation to potentially drive the Department to enhance the process in the next 1 to 3 years.

Assessment sessions were led by a Public Knowledge staff team consisting of a Consultant, who facilitated the session, and a Scribe, who documented the results. The Public Knowledge team compiled and distributed MITA Framework 2.0 Business Capabilities Matrix Information for processes to be discussed prior to each session. The Public Knowledge team also distributed an Assessment Session Agenda prior to each session. A template of these documents can be found in Appendix C. A projector was used to ensure real-time validation of session results.

The Public Knowledge team distributed an Assessment Session Results Document to participants following each meeting. A template of the Results Document can also be found in Appendix C. Participants were responsible for reviewing the results and either validating them or providing corrections to Public Knowledge. Once all corrections were made and validation was received, the work for a session was considered complete.

Subsection 3.3 Tools Used to Conduct Assessment

Three primary tools were used to conduct the Colorado State Self-Assessment: an Assessment Session Agenda, an Assessment Session Results document, and MITA Framework 2.0 Business Capabilities Matrix Information. A sample matrix for the Manage Health Services Contract business process from MITA Framework 2.0 as well as a template of the session agenda and results document are provided in Appendix C.

The Assessment Session Agenda document provided a guide to participants of the upcoming Assessment Session. It defined the processes to be discussed, designated the staff expected to attend, and highlighted the details of each process to be discussed. All session agendas were distributed to invited participants at the beginning of the assessment process so there would be sufficient time for participants to prepare.

The Assessment Session focused on documenting Colorado variations to the business process as described in the MITA Framework, impending policy changes and their impact on the process, potential legislation impacting the process, interfaces with other information systems, and an assessment of the business capability level, including rationale for the capability designation. The Assessment Session Results document is the record of the discussion that took place in each assessment meeting. Each Assessment Session Results document was emailed to participants following the meeting with a request to review and provide any changes necessary to correctly reflect the information discussed in the meeting. All of the Assessment Session Results documents are included in Appendix D.

The MITA Framework 2.0 Business Capabilities Matrix provides a general description for each level along with more specific qualities. Qualities are specific, measurable capabilities including timeliness of business process, data accuracy and accessibility, ease of performance/efficiency, cost effectiveness, quality of process results, and value to stakeholders. Nearly a third of the 79 standard Medicaid business processes in the MITA Framework have no descriptions available for any level or quality. In addition, of the two-thirds that do have matrixes, most of the business processes have only the general descriptions available in the MITA Framework 2.0. CMS recommended in the MITA Framework 2.0, Part I, Appendix E distributed at the 2007 MMIS Conference held in mid-August that states should make their own decisions regarding what each level represents.

Subsection 3.4 Assessment Participants

Approximately 40 Department IT and policy staff participated in sessions to document the "As Is" business capabilities. More staff were invited to participate but were unable to attend. Participants were chosen to participate because of their subject knowledge in relation to specific business processes.

Steve Nelson
Cynthia Oten
Nathan Culkin
Dianne Dunn
Peggy Beverly
Timothy Maloney
Vernae Roquemore
Diane Zandin
Roberta Lopez
James Coghlan
Carol Reinboldt
Joan Welch
Terri Davis
Sharon Brydon
Jerry Smallwood
Laurel Karabatsos
Jenny Nickerson
Dan Roderiguez
Keith Clay
Mark Gray
Steve Holland
Steve Hunter
William Heller
Thomas Walsh
Gary Ashby
Vincent Sherry
Catherine Traugott
Kimberly Eggert
Jessica McKeen
Margaret Mohan
Barbara Prehus
Adel Soliman
Juanita Pancheco
Peter Strecker
John Bartholomew
Teresa Knaack
Patricia Warren
Sandy Barnes
Jed Ziegenhagen
Mark Seevers

State Self-Assessment Profile

As Public Knowledge prepared to assist the Department in developing this State Self-Assessment Profile it was proposed that in addition to the "As Is" and "To Be" business capability of the process that the rationale for the level designation be captured. The rationale provides a picture of the information used to develop the baseline profile. CMS did not provide guidance for the profile until after Colorado's assessment meetings were complete. Once CMS provided guidance for the format of the profile in mid-August at the 2007 MMIS Conference, Public Knowledge recommended that both the original Public Knowledge proposed format and the CMS format for the profile be included in the final document. The following table represents the information to be included in the original profile and communicates to the Department why each chosen level characterizes the "As Is" designation:

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for Maturity Designation

The CMS State Self-Assessment Profile model to be attached to the APD/RFP includes 6 columns of information. This information is intended to support any request for enhanced funding for enhancements or procurement as well as communicate to potential contractors the current and target capabilities of each of Colorado's business processes.

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability

The 6 columns document information from the MITA Framework in relation to the State business processes. The following table provides the definition of the information that is captured in each of the 6 columns in CMS' version of the profile and is taken from the new Appendix E of MITA Framework 2.0, Part I distributed by CMS at the 2007 MMIS Conference:

Column Name	Column Description
MITA Business Area	Use MITA names and order
State Business Area	Use State names and show differences. There may be more State business areas (or fewer). Place State business areas with no MITA equivalent at the end of the profile for each MITA business area.
MITA Business Process	List MITA Business Area and Business Process code. Use MITA name and order/sequence. Complete list of MITA business processes for each business area, then proceed to the next business area/business process list.
State Business Process	Use State's naming convention. Indicate N/A if State does not have this MITA Business Process or any equivalent. At the end of each business area, include Sate business processes not found in MITA. State may have many business processes to each MITA business process.
As Is Level of Business Capability	Refer to MITA Framework 2.0, Part I, Appendix D. Use description of Level and Attributes to aid in designation of Level. Some descriptions are not fully developed. State makes its own decision regarding Level. Must meet all criteria of the level; no 1.5.
To Be Level of Business Capability	State selects its target for improvement. Use description of Level and Attributes to aid in designation of Level. Some descriptions are not fully developed. State makes its own decision regarding Level. Must meet all criteria of the level; no 1.5.

The CMS format of the profile is included as Appendix A and the Public Knowledge proposed format is included as Appendix B.

Business Area Assessment Summaries

The Capability Level for each Business Process Area is summarized in this section. Capability levels are described in the MITA Framework 2.0 as follows:

- Level 1 – mostly manual, uncoordinated, staff intensive
- Level 2 – moving to more electronic, more coordination within the agency, less staff intensive
- Level 3 – using MITA standard interfaces (these interfaces have not been developed yet), increased coordination with other state agencies
- Level 4 – highly electronic, sharing data regionally with other states, relies on technology not readily available
- Level 5 – all electronic, sharing data nationally with all states and federal agencies, relies on technology not yet on the market

The levels are intended to communicate the capability of the business process in relation to the MITA. A couple of guidelines were considered in assigning the capability level for each State business process.

1. It is expected that all states completing a State Self-Assessment will determine their "As Is" business processes at a Level 1 or Level 2 since, in most cases, the technology to justify a Level 3, 4 or 5 is not readily available. For example, one Level 3 criteria mentioned in most of the business capability matrices states, "MITA standard interfaces are used…" These MITA standard interfaces have not been defined yet.
2. The business process must meet all criteria listed for the capability level in the Business Capability Matrix for the State to assign a particular capability level.

A summary business capability level, along with findings and recommendations are provided for each of the MITA Business Process Model Areas assessed during Colorado's MITA State Self-Assessment. The recommendations provided represent solutions that will help the State move closer to the next level of business capability. In most cases, the State will have to implement more solutions than those identified to meet all the criteria to have a business process be considered at the next level of capability.

Member Management - Level 1 (mostly manual, uncoordinated, staff intensive)

The MITA's Member Management business processes are:

- Determine Eligibility,
- Enroll Member,
- Disenroll Member,
- Manage Member Information,
- Inquire Member Eligibility,
- Perform Population and Member Outreach,
- Manage Applicant and Member Communication, and

- Manage Member Grievance and Appeal.

The Client Services section of the Department is responsible for these processes in Colorado. Two of the processes (disenroll member and manage member grievance and appeal) were not evaluated because business capability levels are not defined in the framework.

Finding(s): Staff designated four of the six evaluated processes as Level 1. The Manage Member Information process would have been a Level 2 except the State pays capitated premiums on a monthly basis rather than a daily basis. It is unclear if the system can support the calculation of capitated premiums on a daily basis versus a monthly basis if the State's policy was changed to allow this functionality. The other three Level 1 business processes (enroll member, perform population and member outreach, and manage applicant and member communication) are mainly manual, require more staff resources, and lack coordination among programs. The remaining two business processes evaluated (determine eligibility and inquire member eligibility) were designated as Level 2 because they utilize standard transactions or rules based engines resulting in more consistent responses and require little or no staff intervention.

Recommendation(s): First, the State should determine if the system could support calculation of the capitated premium payment on a daily basis rather than the monthly basis and then determine the impact of changing the policy to support this change. If the State is able to move to a daily premium capitation policy then the Manage Member Information business process could move to a Level 2 designation.

The criteria in the business process matrices for the Member Management area indicate a movement to more coordination and consistency in messages and responses. As such, the State should leverage functionality through their existing Automated Voice Response System (AVRS) and Electronic Data Interchanges (EDI) tools to promote consistent responses to client requests for information regarding benefits, programs, and providers. In addition, the State should consider the integration of an area within the web portal targeted at clients. The client web portal could provide standard information about benefits, programs and providers. In the past, Colorado has considered making kiosks available at community access points throughout the State. These kiosks are another tool the State could use to provide standard messages to clients. The success of these automated tools will require the State to coordinate development of messages responding to frequently asked questions, marketing materials, benefit and program materials. The integration of client functionality in the AVRS, EDI and web portal and availability of kiosks will assist the State in moving closer to a Level 2 designation in three of the business processes.

Provider Management - Level 1 (mostly manual, uncoordinated, staff intensive)

The MITA's Provider Management business processes are:

- Enroll Provider,
- Disenroll Provider,
- Manage Provider Information,
- Inquire Provider Information,
- Manage Provider Communication,
- Manage Provider Grievance and Appeal, and
- Perform Provider Outreach.

The Provider Services section of the Department is responsible for these processes in Colorado. One of the processes (disenroll provider) was not evaluated because business capability levels are not defined in the framework.

Finding(s): Colorado's Provider Management business processes meet many of the criteria to be a Level 2 (moving to more electronic, more coordination within the agency, less staff intensive) but remain a Level 1 because CMS requires that all criteria be met in order to designate a process at a certain level. The State has expanded use of electronic means to distribute and collect information from providers over the past few years. The Web Portal gives providers many self-service business processes that previously would have required the provider to call provider services for information such as another provider's contact information. The recently added Specialty Look-up allows providers an easy search function for finding certain types of providers. In addition, Colorado providers have the option to receive program communication (bulletins) through email but ¾ of providers still opt for paper bulletins that are sent out monthly by the Department.

The State does not have any automated business rules in place to ease the burden of enrolling providers. Enrolling providers is a time-intensive, manual process because most of the information has to be manually verified by staff. In the capture and maintenance of provider data, any use of automated data loads from external sources is still manually verified before it is made available. Other processes that rely heavily on manual processes are the Manage Provider Grievance and Appeal process and Perform Provider Outreach process. Though, provider billing manuals and related documentation are available through the provider services website, the documents are maintained and developed manually and uploaded to the website.

Recommendation(s): In order to move closer to a Level 2 designation for the Manage Provider Grievance and Appeal process, the State should consider accepting reconsiderations electronically to assist in tracking and increase the timeliness in turnaround of these appeals.

The State should also evaluate developing and implementing an online, electronic provider manual that can be viewed and printed by Colorado providers. The electronic manual could eliminate the delay required for IT staff to upload updated documents to the website and would allow inaccuracies to be addressed immediately. The electronic manual would move the State closer to a Level 2 designation for the Perform Provider Outreach process.

Contractor Management - Level 1 (mostly manual, uncoordinated, staff intensive)

The MITA's Contractor Management business processes are:

- Manage Health Services Contract,
- Award Health Services Contract,
- Close-out Health Services Contract,
- Manage Administrative Contract,
- Award Administrative Contract,
- Close-out Administrative Contract,
- Manage Contractor Information,
- Inquire Contractor Information,
- Perform Potential Contractor Outreach,

- Manage Contractor Communication, and
- Support Contractor Grievance and Appeal.

The Contract Administration section of the Department is responsible for these processes in Colorado. Four of the processes (award administrative contract, close-out administrative contract, manage contractor information, and inquire contractor information) were not evaluated because business capability levels are not defined or were not defined appropriately in the framework.

Finding(s): The majority of business processes in this area are manual. Colorado manually receives, reads, and scores proposals for Health Services Contracts. The Department utilizes the BIDS procurement system to announce Request for Proposals but does not allow electronic responses to these requests. The process to close-out a Health Services Contract is also manual based on the termination or transition procedures outlined in the contract. In the case of managing a Health Services Contract, the Department does use electronic means to exchange enrollment files and standardized contractor reporting templates that are submitted to the Department via email. The process still relies on manual processes to gather requirements and develop the RFP for Health Services contracts. In the case of Administrative Contracts, the contract management is not centralized or consistent, monitoring systems are not established for every contract, and quality and accuracy are responded to on a complaint basis. There has been recent movement to more standardization of processes related to contract management and monitoring including the creation of a Service Level Agreement template so that contractor measurement criteria is the same across contracts. Standards for contract management have been created but have not been proliferated throughout the Department.

In the performance of potential contractor outreach, the outreach is legislative driven rather than triggered by agency-wide processes. Outreach is defined by procurement rules for certain types of contracts and conducted differently by different programs. The Department does not conduct outreach based on electronic health records (EHRs) and electronic clinical data available through registries, electronic prescribing, or socioeconomic indicators. Communication with existing contractors is very standardized and somewhat automated with the MMIS contractor but not with all contractors. Grievances and appeals are handled centrally but paper-based. All contractor grievances and appeals are kept in paper files in order to review the decisions when similar actions are filed in the future.

Recommendation(s): The Department needs to proliferate standards for contract management and monitoring to all those responsible for these activities. The standards are only effective when they are available and in use. The management and monitoring of contracts should be consistent from contract monitor to contract monitor. The Department should consider establishing specific performance measures that are consistently applied to all contracts so it can measure the effectiveness of one contract to the next. In addition, the Department should obtain access to or volunteer to participate in the Contractor Performance Database created by SB228-07. The information available in the database may support the work assigned to contract monitors.

In the future, the Department should scan paper grievance and appeal files into an electronic system. To be most effective the Department should use optical character recognition (OCR) in order to support indexing of the information in the documents. Loading these documents into an electronic data management system would allow staff to search and find related grievances and appeals and view easily how the issues were resolved.

Staff would save significant time from having to search through paper files and resolutions would likely be more consistent.

Operations Management - Level 2 (moving to more electronic, more coordination within the agency, less staff intensive)

The Operations Management Business Area of the MITA involves 26 business processes that fall under seven business process sub-areas. The business process sub-areas are:

- Payment and Reporting,
- Claims Encounter Adjudication,
- Capitation and Premium Preparation,
- Payment Information Management,
- Member Payment Management,
- Cost Recoveries, and
- Service Authorization.

The Operations Management section of the Department is responsible for these processes in Colorado. Four of the underlying processes (apply claim attachment, calculate spend down, authorize treatment plan, and authorize referral) were not evaluated because Colorado does not conduct the business process or does not conduct it as defined by the MITA.

Finding(s): In most cases the processes were designated at a Level 1 because the Department relies on non-standard electronic files and transactions as well as paper forms. The HIPAA Electronic Transactions and Code Sets rule required states to start conducting more business using standard transactions. Short timeframes for compliance and limited state budgets forced states to minimally implement standard electronic transactions. Many of the transactions provide for administrative simplification if used to their full potential. Expanding the use of the 837 claims transaction would improve process efficiencies for the prepare COB, manage payment information, manage recoupment, and manage TPL recovery business processes. In addition, the ongoing delay in the final rule for the 275 Claim Attachment effects the improvement of certain business processes. The State is waiting for a final rule to make any changes to it claim attachment business process.

The State relies on the Provider Claim Report to supplement the information available on the HIPAA 835 payment advice transactions. The report provides additional information regarding a provider's claims to support the reconciliation to payment. This report is available electronically through an electronic bulletin board. The Department sees the report as essential because the reject reason codes on the 835 are too generic and do not provide enough information to support reconciliation in most cases.

Several of the State's business processes meet most of the criteria for a Level 3 designation but this level consistently requires the use of MITA standard interfaces. MITA standard interfaces have not been defined yet.

Recommendation(s): In order to move most of its Level 1 designated process to a Level 2 and some Level 2's to Level 3, the Department needs to expand its use of standardized electronic transactions. Using the 278 Authorize Service with automated Prior Authorization business rules the Department would see significant efficiencies in the Authorize Service business process. The Department needs to expand the use of the 837 transactions in conducting coordination of benefits. The Department could save time and

effort both for themselves and their providers if they submitted or forwarded claims directly to other payers instead of back to providers.

In relation to Medicare premium payments, the Department needs to continue to follow CMS' lead for process improvement in this area. The states are constrained in Medicare premium payment process improvement by what CMS requires.

Finally, the Department should consider whether or not time and resources could be saved and the process improved by authorizing Treatment Plans rather than requiring that each individual service in a treatment plan have a separate authorization. Authorizing at the plan level may reduce the number of authorization to be reviewed by staff.

Program Management - Level 1 (moving to more electronic, more coordination within the agency, less staff intensive)

The Program Management Business Area of the MITA involves 17 business processes that fall under six business process sub-areas. The business process sub-areas are:

- Benefit Administration,
- Program Administration,
- Budget,
- Accounting,
- Program Quality Management, and
- Program Information.

The Agency Administration and Operations section of the Department is responsible for business processes that fall under the budget and accounting sub-areas and the Program/Policy Management section of the Department is responsible for the business administration, program administration, program quality management, and program information sub-areas. Ten of the 17 processes were not evaluated because business capability levels are not defined in the framework.

Finding(s): Participants reported that most of the processes evaluated in this business process area are manual because they require knowledge and expertise to ask the right questions, to evaluate options or data, and to make policy decisions. In a lot of cases decisions are not based on clinical data but on regulatory requirements and financial impact. Once decisions are made by the Department, changes to the system are communicated through transmittals to the Fiscal Agent including the authorization to load electronic data from CMS or other entities such as First Data Bank.

Other processes that rely on manual processes are related to the management of federal and State funds. Where possible these processes are automated such as the electronic submission of required reporting to CMS even though these reports are manually built prior to transmission. The Generate Financial and Program Analysis/Report process depends on two systems to conduct sufficient analysis to manage the Colorado Medicaid program and related programs. The MARS subsystem of the MMIS does not allow analysis of health needs and outcomes but is crucial for transaction and discrete person vs. person analysis. The DSS provides more flexibility in reporting and analysis. The Department requires both systems to meet 100% of the reporting and analysis needs of the programs.

Recommendation(s): The Department should evaluate the use of a business modeling tool that could automate some of the analysis that is performed manually for the Design Approved Service/Drug Formulary and Develop and Maintain Benefit Package

business processes. When using a business modeling tool, the Department can simulate how a change in formulary/benefit package will affect the program before it is actually implemented into the system.

The Department should also determine if the manual process to build certain federal reports (CMS 37 and 64) can be automated. The Department should consider during the next procurement of the MMIS to evaluate eliminating the transmittal processes by procuring or enhancing the MMIS so that State staff can execute some or all of the file updates and benefit package updates and creations.

Business Relationship Management – Not Assessed

The MITA's Business Relationship Management business processes are establish business relationship, manage business relationship, manage business relationship communication, and terminate business relationship. The MITA Framework version 2.0 does not contain a business capability matrix for any of these processes so none of these processes were evaluated during this assessment.

Program Integrity Management – Not Assessed

The MITA's Program Integrity Management business processes are identify candidate case and manage case. The MITA Framework version 2.0 does not contain a business capability matrix for either of these processes so none of these processes were evaluated during this assessment.

Care Management – Not Assessed

The MITA's Care Management business processes are manage Medicaid population health, establish case, manage case, and manage registry. The MITA Framework version 2.0 does not contain a business capability matrix for any of these processes so none of these processes were evaluated during this assessment.

Considerations for the Future

States have been consistently looking for and working on opportunities to streamline business processes in an effort to become more efficient. The MITA initiative and its State Self-Assessment process may allow the State to identify additional opportunities for business process improvement and savings through the sharing of best practices among states.

This high-level evaluation and determination of each business process' "As Is" capability is the first step in a multiple step process to bring the Department's Medicaid architecture into alignment with the MITA. The State needs to plan and perform the following activities:

5. **Review Assessment Results with Policy staff.** The Department of Health Care Policy and Financing, IT Division took the opportunity at the end of the MMIS Re-procurement Project to conduct a high-level State Self-Assessment. The Division identified IT staff and some business staff to participate in the assessment sessions. It became apparent through the assessment sessions that additional program and policy staff would have added significant value to the identification of the capability level of each business process. In order to make certain that all viewpoints of each business process are represented in the results of the assessment, the Department should review the "As Is" results of the assessment with policy and program staff and make necessary revisions to the State Self-Assessment Profile.

   In addition, the Department should consider taking this opportunity with IT, policy and program staff to document and map its business processes that it uses to manage and deliver Medicaid and related program services to its clients. A significant amount of business knowledge resides in individual staff's heads and is not documented formally anywhere. Since, knowledge transfer is important as staff retire or move to other positions, this business process documentation assists new or reassigned staff to perform their responsibilities.

6. **Document "To Be" Capability for Each Business Process.** The MITA State Self-Assessment is an opportunity for Colorado to develop a vision of the Department's Medicaid Enterprise. This strategic vision should include documenting goals and objectives of the organization and the development of outcome measures to determine how well the Department is achieving its goals and objectives over time. Once the Department's management documents a strategic vision for the Medicaid program, management can designate a "To Be" capability for each business process that aligns with the Medicaid strategic vision.

7. **Develop MITA Transition Plan.** Following the designation of the "To Be" capability for each business process, the Department will need to develop a plan to take action to move from one capability level to the next. The Department's MITA Transition Plan should prioritize business process and system improvement activities that focus on those opportunities that bring the greatest return for the Department. These returns should be measured against the performance outcomes established by management

during strategic planning. Measures could include staff number, time, and financial resources. This plan will provide guidance to those responsible for transition in executing projects that move the Department's Medicaid architecture to a higher capability level in the MITA.

States will be expected to conduct ongoing reassessment of business processes as enhanced funding is requested from CMS in coming years. As the Department develops its plan for transition to the MITA, it needs to determine and implement efficient processes to reassess business processes in order to update the State Self-Assessment Profile and to address future versions of the framework as they are released over the next 10+ years. Implementing these processes from the beginning will make certain that the Department does not have to expend significant funds or staff time to address the rollout of the Information and Technology Architectures of the MITA.

8. **Monitor the Evolution of the MITA.** The MITA Framework became widely available to states in March 2006 though it contains significant gaps in information. Of the three architectures involved in the MITA, the Business Architecture is the most complete. CMS has encouraged states to move forward with completing a State Self-Assessment even though more than a third of the business processes for which states are determining business capability levels do not have a defined Business Capability Matrix. It is important that the Department monitor CMS activities to refine the MITA Framework over the next 10+ years. CMS approval of enhanced funding will eventually be intertwined with the activities the State is undertaking to align its Medicaid architecture to the MITA.

Appendix A – State Self-Assessment Profile – CMS Format

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
Member Management	Client Services	ME Determine Eligibility	Determine Client Eligibility	Level 2	Level 3
		ME Enroll Member	Enroll Medicaid Client	Level 1	
			Enroll CHP+ Client	Level 1	
		ME Disenroll Member	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		ME Inquire Member Eligibility	Inquire Client Eligibility	Level 2	
		ME Manage Member Information	Manage Client Information	Level 1	
		ME Perform Population and Member Outreach	Perform Client Outreach	Level 1	Level 2
		ME Manage Applicant and Member Communication	Manage Applicant and Client Relations	Level 1	Level 2
		ME Manage Member Grievance and Appeal	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
Provider Management	Provider Services	PM Enroll Provider	Enroll Provider	Level 1	Level 2
		PM Disenroll Provider	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PM Manage Provider Information	Manage Provider Information	Level 1	

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
		PM Inquire Provider Information	Inquire Provider Information	Level 2	
		PM Manage Provider Communication	Manage Provider Relations	Level 1	
		PM Manager Provider Grievance and Appeal	Manage Provider Grievance and Appeal	Level 1	
		PM Perform Provider Outreach	Perform Provider Outreach	Level 1	Level 2
Contractor Management	Contract Administration	CM1 Manage Health Services Contract	Monitor Contract	Level 2	
		CM1 Award Health Services Contract	Award Contract	Level 1	
		CM1 Close-out Health Services Contract	Close-out Contract	Level 1	
		CM2 Manage Administrative Contract	Monitor Contract	Level 1	Level 2
		CM2 Award Administrative Contract	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		CM2 Close-out Administrative Contract	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		CM3 Manage Contractor Information	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		CM3 Inquire Contractor Information	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
		CM4 Perform Potential Contractor Outreach	Perform Potential Contractor Outreach	Level 2	
		CM4 Manage Contractor Communication	Contractor Communication	Level 1	
		CM4 Support Contractor Grievance and Appeal	Contractor Protest	Level 1	
Operations Management	Agency Administration and Operations	OM1 Authorize Referral	N/A	Colorado does not perform this process as defined by the MITA Framework 2.0.	
		OM1 Authorize Service	Prior Authorization	Level 1	
		OM1 Authorize Treatment Plan	N/A	Colorado does not support treatment plans as a way of authorizing a group of services. The State does not meet any criteria of any level in business capability matrix.	
		OM2 Apply Claim Attachment	Apply Claim Attachment	Currently this process is not supported as MITA defines it because if a claim requires an attachment it must be submitted on paper. Colorado does not meet any criteria of any level in business capability matrix.	
		OM2 Apply Mass Adjustment	Apply Mass Adjustment	Level 2	
		OM2 Audit Claim/Encounter	Audit Claim/Encounter	Level 2	
		OM2 Edit Claim/Encounter	Edit Claim/Encounter	Level 2	
		OM2 Price Claim/Value	Price Claim	Level 2	

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
		Encounter			
		OM3 Prepare COB	Prepare COB	Level 1	
		OM3 Prepare EOB	Prepare EOMB	Level 1	Level 2
		OM3 Prepare HCBS Payment	Prepare HCBS Payment	Level 2	
		OM3 Prepare Premium EFT/Check	Prepare Premium EFT/Check	Level 2	
		OM3 Prepare Provider EFT/Check	Prepare Provider EFT	Level 2	
		OM3 Prepare Remittance Advice/Encounter Report	Prepare Remittance Advice/Encounter Report	Level 2	
		OM4 Prepare Capitation Premium Payment	Prepare Capitation Premium Payment	Level 1	
		OM4 Prepare Health Insurance Premium Payment	Prepare HIBI Payment	Level 1	
		OM4 Prepare Medicare Premium Payment	Prepare Medicare Buyin Payment	Level 2	
		OM5 Inquire Payment Status	Inquire Payment Status	Level 2	
		OM5 Manage Payment Information	Manage Payment Information	Level 2	
		OM6 Calculate Spend-	N/A		

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
		Down Amount			
		OM6 Prepare Member Premium Invoice	Prepare CHP+ Client Premium Invoice	Level 2	
		OM7 Manage Drug Rebate	Drug Rebate	Level 2	
		OM7 Manage Estate Recovery	Estate Recovery	Level 2	
		OM7 Manage Recoupment	Overpayment Recovery	Level 1	
		OM7 Manage Settlement	Manage Hospital Cost Report Settlement	Level 2	
		OM7 Manage TPL Recovery	Manage TPL Recovery	Level 1	Level 2
Program Management	Program/Policy Management	PG1 Designate Approved Service/Drug Formulary	Designate Approved Service Formulary	Level 1	Level 2
			Designate Approved Drug Formulary	Level 1	Level 2
		PG1 Manage Rate Setting	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PG1 Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	Level 2	Level 3
		PG2 Develop and Maintain Program Policy	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
		PG2 Maintain State Plan	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PG2 Develop Agency Goals and Initiatives	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
	Agency Administration and Operations	PG3 Manage Federal Financial Participation for MMIS	Manage Federal Financial Participation	Level 1	
		PG3 Formulate Budget	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PG3 Manage State Funds	Manage State Funds	Level 1	
		PG3 Manage F-MAP	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PG4 Manage 1099s	Manage 1099s	"TBD" – accounting staff not available	
		PG4 Perform Accounting Functions	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
	Program/Policy Management	PG5 Develop and Manage Performance Measures and Reporting	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PG5 Monitor Performance and Business Activity	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PG6 Manage Program Information	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PG6 Maintain Benefit/Reference Information	Maintain Reference Data	Level 1	Level 2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	As Is Level of Business Capability	To Be Level of Business Capability
		PG6 Generate Financial and Program Analysis/Report	Generate Reports	Level 2	
Business Relationship Management	Contract Administration	BR Establish Business Relationship	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		BR Manage Business Relationship	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		BR Manage Business Relationship Communication	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		BR Terminate Business Relationship	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
Program Integrity Management	Program Integrity	PI Identify Candidate Case	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		PI Manage Case	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
Care Management	Contract Administration	CM Establish Case	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		CM Manage Case	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		CM Manage Medicaid Population Health	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	
		CM Manage Registry	TBD	"TBD" – Business Capabilities not Defined in MITA Framework 2.0	

Appendix B – State Self-Assessment Profile

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
MEMBER MANAGEMENT						
Determine Eligibility		"AS IS"	"TO BE"			• Limited "No Wrong Door" initiative. • They do not enable consumer driven healthcare. • Potential for data loss in data smushing process between CBMS and MMIS. • Cash, Food, and Medical benefits are all determined in the same system through CBMS but two different Departments are responsible for eligibility policy. • Colorado does not do Spend Down. • There is a single purpose application (SPA) • There are Presumptive Eligibility and Medical Assistance sites with accessibility. • Applicants cannot initiate applications from home that easily other than the mail-in for CHP+ - however, the structure is there.
Enroll Member	"AS IS"					• HCBS is automated, but not integrated with MMIS. • Staff are still manually applying business rules. • HCBS still manually verifies information. Managed care does not.

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						• Enrollment is different from client to client. Clients get to choose. The choices are automated, but what the client does in response are not. • Maximus has an interface that they use to create paper applications. • No separate application process is necessary. • Staff size is moderate. They are on contract but they don't have that many people and have lost funding.
Disenroll Member	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Inquire Member Eligibility		"AS IS"				• MITA Standard interfaces have not been defined yet. • Colorado supports HIPAA standard 270 and 271 • Colorado supports HIPAA standard NCPDP formats • Have AVR web portal. • Integrated records of member eligibility – 271 – managed care enrollment, lock-in enrollment, and resources. • Immediate responses are made. • Exceptions – CMS imposed a date limit – could only go back to 7/17/06 to check eligibility – 1 year limit for access. • No plans to integrate inquire eligibility functions with other agencies outside

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						of Medicaid or entities.
Manage Member Information	"AS IS"					• Colorado has some new/expanded client populations due to recent initiatives for which they will not have very much information about – Presumptive Eligibility and Colorado Care Prescription Drug Discount. • Business process extended by workarounds to meet needs of the program. • Colorado does rules based validation and data reconciliation. • The MMIS maintains audit trails for client data. • The centralized registry is not entirely integrated. There is client eligibility information in CBMS that HCPF doesn't maintain. • Member updates are timely for the most part. • Automated updates can be made to individual client files. • The automated process results in less staff. • Capitated MCO premiums are paid on a monthly rate per policy. • Automation improves the accuracy of validation and reconciliation and makes timely and accurate data available. Enrollment of rosters, etc. • Limited "No Wrong Door" initiatives –

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						they can go to any state office and get service. • Technology support is provided by service oriented architectures and rules engines. The web portal is service oriented but not all functionality is a classic rules engine because it is not user maintainable. The state still has to have a fiscal agent.
Perform Population and Member Outreach	"AS IS"	"TO BE"				• Coordinated among programs. • Manual – paper or phone, but there is some electronic work. • Identification of targeted members based on member records. • Sporadic outreach that is not well documented. • There is some analysis done on un-insured. • Hard to locate based on programs. • There are bilingual programs (Spanish or English), but not Russian or Vietnamese or Hmong • Difficult to maintain consistency. • Outreach stuff for CHP+ is there for level 2. • Manual process. Takes the time it takes. • Material preparation is clunky.
Manage Applicant and Member Communication	"AS IS"	"TO BE"				• Uncoordinated. • Not systematically triggered. • Not always linguistically appropriate. • Client contact information is incorrect

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						or not captured. • Non-standard formats. • Inconsistent and manual responses. • Delayed responses. • Medical ID card is somewhat automated. There is a three day delay in the ability to receive benefits. • Do not have a client portal yet – but there is a plan to integrate one. • Maximus is interested in maintaining and expanding their role. The redetermination date is sent such that they can send another package that encourages enrollees to redetermine eligibility. • Not sure if a member can call in and determine if they are covered or if they have pharmacy access and/or prescriptions filled. • MITA Standard interfaces have not been defined yet.
Manage Member Grievance and Appeal	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
PROVIDER MANAGEMENT						
Enroll Provider	"AS IS"	"TO BE"				• Do not have web based applications yet. However, the application is on the web and you can download it from there and print it out and send it. • Business rules – The ID is automatically assigned. Rates are manually computed. They don't have automated systems for the

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						credentialing. Providers are enrolled timely, but the accuracy is somewhat reduced. • 2 applications – one for services and one for rendering. Dental was combined. Rendering was created. There is still a ton of documentation requirements for them, but the application is all the same. The pharmacy application is gone. • Performance measures tracked relating to enrollment include operational statistics – number of applications coming in, number changed by transmittal, etc. There are manual counts on this, but they do have automatic tracking capability. • Before and after image audit trail is available. • Level 1: Staff receives and processes business rules. Decisions may take several days (5), but do comply with federal rules. 3 people work on this at ACS. Application information is manually validated when validated at all. • MITA Standard interfaces have not been defined yet.
Disenroll Provider	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
Manage Provider Information	"AS IS"					• Updates are made on the website within 24 hours or 3-5 days if done on paper • Updates are automated if done via the web portal or CLIA. DORA must be reviewed manually if our files don't match DORA records. • Those that are automated are verified for accuracy. • The data entry staff consists of 3 people. • MITA Standard interfaces have not been defined yet.
Inquire Provider Information		"AS IS"				• MITA Standard interfaces have not been defined yet. • Neither EDI nor AVRS apply. You have to have a provider ID already to use these means. • Information can be requested via the web portal. • Responses are not inconsistent or manual. There are not delays. There are immediate, consistent and timely responses. • Vast majority of providers do not know that the specialty look up exists.
Manage Provider Communication	"AS IS"					• Some standardization. • Some electronic through the web portal and some through call-center. • Some providers are mono-lingual. Some do not speak English well enough to conduct business. • Gap in the managed care. Diane's

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						staff does customer service for managed care. She has asked that Provider Services provide the research and answers for why clients show up on some reports and not others. Since it requires system staff to answer questions, the fiscal agent cannot answer the questions, and they have to send the managed care provider to the Department for answers. • Waiver provider communications – completed by Fiscal Agent. • Special providers – completed by Department. • MITA Standard interfaces have not been defined yet.
Manage Provider Grievance and Appeal	"AS IS"					• Do use MMIS but this is still a time-intensive process. Most is manual including research. • Requests are mailed to AG's office when the appeal is desired. • No way to file appeal online. • It is labor intensive, but usually only 1-2 claims per provider per appeal. Not necessary to automate. • Volume – 3 appeals per month. • Appeal at AG's office: 2-3 per month • Reconsiderations – 500-600 claim lines per month. Sometimes one provider wants to appeal a lot. • 150-200 providers per month – this uses MMIS to track in a standardized

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						method and in decision report system to find things. • Automated using MMIS, but not AVRS or Web Portal. Paper driven submissions. • MITA Standard interfaces have not been defined yet.
Perform Provider Outreach	"AS IS"	"TO BE"				• Perform Provider Outreach to target and enrolled providers are not accomplished. Television, radio, etc. are not used to contact providers or potential providers. • Linguistic and cultural deficiencies among the provider community obstruct provision of care to ethnic and immigrant populations. • Manuals are manually prepared and updated. • There is no standard time allotted for manual preparation. • New pages are posted to the portal – not mailed, though the Department can provide a CD of the manual to a provider upon request. • There are inaccuracies and inconsistencies throughout outreach materials. • Electronic media is not unanimously preferred. • Staff develops and maintains materials manually, but they are also maintained on the website. Either edits or Word – track-changes.

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						These are maintained on the website and uploaded on a new version. • Coordinating track-changes back in time is a tough project. • Postal expenses for bulletins have been cut back, but not eliminated. • Bulletins are mailed. Providers have been asked to volunteer to eliminate use of paper bulletins but this is not happening. • Department is trying to group providers and clinics by address to avoid sending multiple copies to one location. • Studies are conducted to see how improvements are made in provider performance and how to improve outreach. Department is in the process of trying to understand how to improve performance and deliver information to providers. Access is not monitored: Department does not know which providers are accessing and which are not.
CONTRACTOR MANAGEMENT						
Manage Health Services Contract		"AS IS"				• It is assumed that these services are direct. The administrative services are not included here. • There are two different systems: physical health care and mental/behavioral health. • In behavioral health, Colorado has a mental health program where they

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						issue an RFP. There are 5 regions in the state. For each region, they select one vendor to serve that entire region. The clients are enrolled in that BHO. They do a waiver with CMS to be able to do the mandatory enrollment and then they can require that the clients be enrolled. This waives the choice requirement. • Preparing for the RFP is a process that they engage in ahead of time to ensure that there are not federal or state regulations. They get stakeholder input and make sure that there are not things that they need. The staff drafts the scope of work. • On the physical health care side, they do not currently do RFPs nor do they have a waiver with the feds. Any willing provider is okay for contracting according to the State procurement rules. If the Department contracts with more than one vendor in one area, the client's enrollment with a particular provider is voluntary. • In both cases, they define the benefits and requirements, and the rates section sets the capitated rates. • The physical health side has HMOs (fully capitated) and prepaid inpatient health plans (PIHP) (not capitated – Fee For Service (FFS)) and vendors get per member per month management fee for doing things, like

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						HMO.) They have a Primary Care Case Management program (another CMS managed care program). This is individual providers who contract with them to agree to be the gate keeper for client services. They pay fee for service for these services through MMIS. The rates for the HMOs and the BHOs are developed by the rates section based on how they define the benefits packages. The rates section also helps verify or establish the appropriate PMPM PIHP. • Colorado exchanges electronic enrollment files with vendors or contractors on a monthly basis so that they can determine which clients are in their plan and ensure that they receive capitation payments for enrolled clients. • Reporting requirements are satisfied through the use of template reports that contractors submit electronically through an email alias set up at the Department.
Award Health Services Contract	"AS IS"					• This is a manual process. Receive, read, score • Proposals are not submitted via web portal. • Application data is standardized within the state. • Verifications are a mix of manual and automated steps.

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						• Decisions are pretty consistent. • The format is determined and defined.
Close-out Health Services Contract	"AS IS"					• The process is not "sophisticated" or very hi-tech. They notify with letters. Internal activities are pretty basic. • The criteria on the matrix do not make sense for this process though. • Contracts are generally paper based due to the need for original signatures, etc. There are electronic signatures, but there are a lot of steps necessary to validate electronic signatures and there is a slim possibility of their having the technology to verify the signatures.
Manage Administrative Contract	"AS IS"	"TO BE"				• Matrix definitions do not appear appropriate for State administrative contracts. • Administrative contracts are all RFP'd by contract, not through application. • Have some standardization. • There is not really a centralized function. The performance requirements monitored is different across the different contracts. Quality and accuracy are responded on complaint basis. • If monitoring system is necessary, they will establish it. They monitor, track, and collect some information as a core data set. There is a specific set of things that are tracked for each

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						contract, some similar and some different based on the contract. • There are similar standards held for all of the contractors. However, the way that the contracts are written dictates how they can enforce the contract. That's where the differences come in. The State has developed an SLA template to use the format and the criteria across contracts. This movement toward standardization is slowly happening. Very manual process. • The contract itself has a model IT template, but most of the time there is deviation from the standard 40 clauses (adding, tweaking, etc). Of the original 40, only about 35 will be the same. Thus, this affects how they monitor because the standard is altered. • For IT contracts, the performance standards are in the RFP along with the scope of work, the contractor responsibilities, and the state responsibilities. The RFP becomes incorporated by reference. There are other areas that do not do that and write a more specific contract. IT offers what they want and the contract in the RFP.
Award Administrative Contract	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					• Matrix definitions do not appear appropriate for Award Administrative Contract process. (copy of matrix for

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						Manage Administrative Contract process)
Close-Out Administrative Contract	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					• Matrix definitions do not appear appropriate for Close-Out Administrative Contract process. (copy of matrix for Manage Administrative Contract process)
Manage Contractor Information	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Inquire Contractor Information	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Perform Potential Contractor Outreach		"AS IS"				• QI does a lot of data analysis and then suggests alterations and develops programs to work on what they find. • CHP does some of this. • HCPF deals with MMIS related contracts. • It is coordinated in the sense that it is legislative driven and funnels down from there. Not haphazard. • May be program specific, but only because looking at the specifics of that program. • There is an effort toward the competitive nature of the bids, driven by the legislative rules. There are siloed programs, but they are systematically triggered by legislation. • They have the data to target

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						appropriate populations from claims or other sources (CDC, etc). • Regarding the contractors who are out there to do the work, there is not great information out there to inform the State of their existence. • The Department has not achieved Level 3 because they do not have electronic signature abilities. There is some electronic utilization but the process is still highly dependent on paper products.
Manage Contractor Communication	"AS IS"					Descriptions for each level in the Matrix are not consistent with the process description provided in MITA Framework 2.0 Part 1, Appendix C. • Prospective Contractors do not have QA processes. • Contractor communication processes are centralized for economy. There is centralized communication regarding the transmittals – recorded, filed, and publicized. • Specific contract managers have communication funneling through them – measuring efficacy. • Other managers may have other systems. There are strict sign-offs for all change requests. This is standardized. There are levels of acceptance for test results, etc. and we are not sure if agency-wide. • There is a certain amount of control over these things. Contract

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						managers should realize when things are more formal and document things. • Other contract managers may be more manual. IT really doesn't know because of the decentralized nature of their systems.
Support Contractor Grievance and Appeal	"AS IS"					• Because there are so few instances (approximately 2 per year) the process is paper-based, but still efficient. • Legal based issues – people have to go to court. • Required by law to have protests and responses on paper. • Procurement is handled for whole agency by Jim. Contracts all come through him and the protests and grievances are handled by him also. • Communications are consistent. • Contractors have access to the rules. They know before filing protests, grievances or appeals what they will be held to from a rule standpoint. • Procurement rules are based on the model procurement code around the country.
OPERATIONS MANAGEMENT						
Authorize Treatment Plan	Colorado does not support treatment plans as a way of authorizing a group of services. The State does not meet any criteria of any level in business capability matrix.					• MMIS does not support the entry of treatment plans. • A unique PAR is required for each service. They cannot be grouped

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						(covering home health, waiver, etc).
Authorize Referral	Colorado does not perform this process as defined by the MITA Framework 2.0.					
Authorize Service	"AS IS"	"TO BE"				• Many forms are paper-based. • Manually validated and transferred from paper to MMIS. • Reviewer manually contacts the submitter/provider. • Manually validated against state specific rules. • Mix of paper, phone, fax, or EDI. • Requests are received through internet Web Portals. Providers can submit service requests electronically. • Authorize service processes do not generate electronic requests around 277. • Unstructured paper forms are used in manual review process, such that inconsistent interpretation and application of PA rules persist. • MITA Standard interfaces have not been defined yet.
Edit Claim/Encounter		"AS IS"				• MITA Standard interfaces have not been defined yet. • Agency receives paper claims conforming to state standards. Data elements trigger edit/audit. • Most providers submit claims via

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						Web Portal, etc. It is electronic submission primarily. (L2) • Transmitters support business processes. • Encounter data – problem in Level 2. BHOs are still doing things on a flat file in parallel to the electronic submission. In transition from one to two now (for HIPAA) • The ability to receive things is there, but the compliance is not yet there. Not used for payment, but you still have to price it. Keeping the data segregated to say which data was submitted and what should be returned. • Waiver process – CO can accept their claims. There are programs that DHS does that are outside of the MMIS and there are some programs that are outside of the MMIS. There are waiver programs external to the system. DHS doesn't do claims processing the same as HCPF does. DHS certifies the providers, and are loaded into the MMIS, but DHS is not necessarily involved. • What does "sister agencies" mean? Not all of the programs are done through the MMIS. They administer some and reimburse them and control them aside from the state. There are some with business arrangements to do the claims

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						processing. • L2 timeliness of process – waiver claims submitted to siloed payment systems. This sounds like the DHS process and it's a payment system for some of those. • From a Medicaid program standpoint, they are centralized and all goes in there waiver or not. • Provider claim report does the 270s via the webportal. • Request for corrections is done through an edit setting on a claim.
Audit Claim/Encounter		"AS IS"				• MITA Standard interfaces have not been defined yet. • This should be the same as the Edit Claim encounter above. • Processes meet HIPAA standards (98% electronic claim process).
Price Claim/Value Encounter		"AS IS"				• MITA Standard interfaces have not been defined yet. • Automatic pricing. • Values assigned based on the same reference data. • Manual pricing is NOT done oln encounters, but there is some on claims. • Staff adjustments – atypical provider services are NOT manually priced. Provider advances are manual. Member contributions are all taken from the claim as are recoupments. Deduction of liens is handled outside

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						of the MMIS. Waiver services are handled normally through the same process as everything else • Most manual pricing is done on claim type I (Medical Supply) – for different equipment etc. based on invoices. That data is loaded in the system in a different way. • Single claim adjustments are automated using the webportal. Adjustments are submitted using an 837. • Pricing formulas are agency specific. DHS prices are done through a PAR – automated. There are not manually priced waivers for atypical providers.
Apply Claim Attachment	Currently this process is not supported as MITA defines it because if a claim requires an attachment it must be submitted on paper. Colorado does not meet any criteria of any level in business capability matrix.					
Apply Mass Adjustment		"AS IS"				• MITA Standard interfaces have not been defined yet. • Primarily electronic. • Mass Adjustments are identified electronically. They can mass adjust back to specific dates. • There are audit trails. They produce adjustment analysis reports so that you can see the differentiation. Sometimes the post-adjudication amounts are inaccurate. The actual history maintains the TCNs of the adjustments that come after it (all

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						will be noted). • There are links that mark the Mass Adjustment of the most recent and only that claim would be active.
Prepare Remittance Advice/Encounter Report		"AS IS"				• MITA Standard interfaces have not been defined yet. • Medicaid agency provides paper RAs to providers who are not electronic billers. • The agency complies with HIPAA to supply an electronic RA that meets State agency implementation guide. • Offered on paper by exception for new providers. Moving to total electronic.
Prepare COB	"AS IS"					• Medicaid agency uses the resource intensive model to submit denied claims to other payers. However, the cost avoided claims are not forwarded to primary payers. • Colorado has a mix of paper and EDI claims with non-standard data. • Post-payment information is sent on paper. Post-payment recovery is primarily manual and mostly paper-based. • Letters go to the carriers. HMS generates claim letters and forms. • MITA Standard interfaces have not been defined yet.
Prepare HCBS Payment		"AS IS"				• MITA Standard interfaces have not been defined yet. • Enroll the providers with the same

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						information. • Have to do EFT • Have to do electronic billing. Paid with a claim • Becoming more like one another not less. • Services are expanding.
Prepare EOB	"AS IS"	"TO BE"				• The sampling process does not target selected populations. • Sensitive services can be suppressed. There are diagnosis codes and classes of drugs. • They do this monthly (not quarterly). • All performed in English. • MITA Standard interfaces have not been defined yet.
Prepare Provider EFT/Check		"AS IS"				• MITA Standard interfaces have not been defined yet. • Conforms to HIPAA. • Agency encourages electronic billers to adopt EFT payment.
Prepare Premium EFT/Check		"AS IS"				• MITA Standard interfaces have not been defined yet. • Conforms to HIPAA. • Agency encourages electronic billers to adopt EFT payment.
Prepare Health Insurance Premium Payment	"AS IS"					• Colorado does not use HIPAA compliant transactions. • HIPAA compliant 820 transaction (premium payment – how they advise managed care plan electronically) – because State Treasurer's Office is the only one

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						who can pay, the 820 is a remittance advice. • If a transaction is generated at all, it would be an 835 transaction that is used to advise payment. • 856 transactions are almost all client payments and hardly any direct insurance provider payments. Over time, they may become more sophisticated, but it's doubtful that they will move toward being HIPAA compliant any time soon. • MITA Standard interfaces have not been defined yet.
Prepare Medicare Premium Payment		"AS IS"				• MITA Standard interfaces have not been defined yet. • Colorado does buy-in for both part A and part B. • Since there is no HIPAA standard, Colorado uses HIPAA transactions to improve their business standards. • Working on the fourth improvement CSR for this process. • Colorado was the second state to comply with CMS's buy-in redesign. • Colorado was the first state to choose daily data exchange.
Prepare Capitation Payment	"AS IS"					• HIPAA-compliant standards are used with the exception of PLA standard. Written it into the APD for the PIHP study that might result in systems changes. • Do not deal with other insurance

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						agencies. • They have a modified claim adjudication process to support capitation payment preparation.
Manage Payment Information		"AS IS"				• This is primarily an electronic process. • Although internal data must be mapped, the ability to compare data across programs has improved. COFRS to MMIS is done manually, with difficulty, and not automatically. Reporting is siloed. • MMIS vs. COFRS – comparing across programs is program to program. • Pharmacy POS – comes to MMIS for recommendation to COFRS and is all in one system. • They do not have a rudimentary decision support system. • Not at level 3 because coordination of benefits is not performed with 837s.
Inquire Payment Status		"AS IS"				• Programs use a centralized automated electronic claim status, etc. • MITA Standard interfaces have not been defined yet.
Calculate Spend-Down Amount	Colorado does not perform this process.					

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
Prepare Member Premium Invoice		"AS IS"				• Do not have anything automated from the bank. • All information can be viewed online. • Notices are automatically generated sent on paper advising of hearing rights and the amount of their contribution. • In Level 3, member liability amounts are not updated by MMIS – this is not a requirement of MMIS. • CBMS is the accounting system for premium payments. They register the payments, and have never had someone overpay. Overpayments and crediting are not automatic.
Manage Recoupment	"AS IS"					• Process receives 837s; no electronic output. • Recoveries are not electronic. • Generally a manual process.
Manage Estate Recovery		"AS IS"				• MITA Standard interfaces have not been defined yet. • Contractor processes are automated. • Extract sent to contractor is electronic. • Check receipt and processing is manual. Should remain manual for quality assurance. • Intake and budgetary inability to see the data – the budget people can get the information from the accounting department. There is a

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						separate grant budget line (GBL) that they can view. • The State does not have the capability of doing what the contractor does, but taking into account the contractor's abilities, the process is a 2.
Manage TPL Recovery	"AS IS"	"TO BE"				• The majority of Colorado's manual validation is for reconciliation and quality assurance purposes. • The State has manual processes to update the client resource file and to recover partial recoveries. • The contractor process is somewhat automated, but less so than for other recovery processes. • MITA Standard interfaces have not been defined yet.
Manage Drug Rebate		"AS IS"				• MITA Standard interfaces have not been defined yet. • Systems electronically interface. • Process is not manual. • Invoices are produced automatically, but mailing, certifying, etc all are manual processes. • Systems are not interoperable
Manage Settlement		"AS IS"				• They have a standardized data set, and good reports. • The cost settlement is done electronically. There are manual audits that they have to keep manual. • HIPAA is not in play because they

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						are analyzing financial costs of reports (not client information). • This is mostly an automated process to the extent that it can be.
PROGRAM MANAGEMENT						
Design Approved Service/ Drug Formulary	"AS IS"	"TO BE"				• They only have one drug formulary, so they don't have siloed systems. They do have one for dual eligibles, but there is not a part D group vs. the regular Medicaid group. They cover Medicaid Part D excluded drugs to the extent that they are covered for all other clients. • Centralized by the enterprise. Standardized systems are centralized by the benefit packages. • Decisions based on fiscal impasse and regulatory requirements. • Don't look at health outcomes when doing formulary – but they are not allowed to by federal law. On the back end – looking at PA, limitations, PDL, and federal law – these are done by clinical. Base formulary is done by law and they have to cover it. They look at clinical things to determine limitations and PAs. They rely on the system pieces to determine if it's a rebateable drug, but there is not necessarily clinical data available. They use utilization data (claims based process).

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						Looking at overall condition of individual clients or even groups of clients from what they can glean from claims data. They look at the pharmacy claims data, diagnosis codes, but going beyond that is difficult. There is a disease management program, but there is not a pharmacy program with that. • Communication of changes is done through the provider bulletin or posting on the website – these are both electronic. • Limited analysis of heath outcomes as a determining factor.
Manage Rate Setting	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Develop and Maintain Benefit Package		"AS IS"	"TO BE"			• In waiver programs, you can choose a service from a variety of providers (individual or agencies); there are different kinds of providers for a service that an individual client may choose. They can also choose home or away from home, etc. Behind the scenes, the system accommodates these choices. Depending on which choice the client makes the provider bills accordingly. • For traditional Medicaid, they have certain criteria, and then there are specifications for waivers that occur.

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						• Not level one because there are not just a few packages. They offer a lot of packages unless on specific eligibility (specific and systems driven, which is not necessarily how things are done). • Looking at the flexibility of the system. IT would need to be here to determine what exactly occurs. IT would help do the workarounds (for example, can't have clients in HMO and in 'x' program…) • There are some elements of level 3 that are applicable because individuals are making choices across benefit packages based on clinical data, member preference, health status, etc. These are not automated packages, but they are still able to make these decisions.
Develop and Maintain Program Policy	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Maintain State Plan	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Develop Agency Goals and Initiatives	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage Federal Financial Participation for MMIS	"AS IS"					• The process is manual. • There is no OCR or AVR. • They do not have point-to-point or wrapped connectivity or interfaces.

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						• Transactions are not received through EDI. They are paper, not electronic. • Electronic invoicing is not done either. • APD process is also manual. • CMS 37 and 64 are submitted electronically, but populating those reports is totally manual.
Formulate Budget	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage State Funds	"AS IS"					• It is a manual process. There is not an OCR, or any electronic means of tracking the process. Though for claims they do have the automated process, but even for them, MMIS does not distinguish what goes where. • Clinical data does not necessarily enter into the management of state funds. It is used to evaluate the use of state funds, but not to manage them. Clinical data refers to the PA process of claims. • They use MMIS for tracking and reports for audit purposes. They have a specific person who audits claims using MMIS and other systems. • Please note for CMS: L1 in this matrix assumes that because it's a manual process it is inefficient. This

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
						is not necessarily true in all cases. L1 does not fully or accurately support the business process description. The L1 description appears to measure the program not the funding of the program and therefore, it feels irrelevant. • The 2nd, 3rd, 4th paragraphs of L1 do not seem to apply to the management of state funds business process. Therefore, this business process is a level one with the exception of the three bottom paragraphs.
Manage F-MAP	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage 1099s	Still need to meet with Accounting people – will incorporate in final report.					
Perform Accounting Functions	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Develop and Manage Performance Measures and Reporting	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Monitor Performance and Business Activity	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage Program Information	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
Maintain Benefit/Reference Information	"AS IS"	"TO BE"				• Some proprietary EDI would be the spreadsheet exchanges. • They have standardized data in the sense that they utilize national codes. • Clinical data is rarely the basis for decisions because it is not necessary. The maintain benefits reference information does not appear to connect to the process description. Program integrity would be with medical records. • Customers have difficulty accessing information – rather, they cannot access information on procedure codes at all. • Communication for members is not done really either. • They are increasing use of electronic interchange. Not doing OCR. • Do have AVR, but not in relation to maintenance. • Agencies are centralizing common process to achieve economies of scale. • They improve rule application consistency in the utilization of the spreadsheets. • These matrices do not really tie back to the process description provided in the Framework.

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
Generate Financial and Program Analysis/Report		"AS IS"				• Business process is increasing its use of electronic interchange and automated processes. • They are not using taxonomies because it's difficult to obtain. They do have things that allow for cross-state information exchange because of the emphasis on CMS-64. • "Agencies" plural is not relevant. There is a single state agency that administers the Medicare program. They all use the same codes within the MMIS. • L2, but tapes are still required by CMS.
BUSINESS RELATIONSHIP MANAGEMENT[1]						
Establish Business Relationship	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage Business Relationship	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage Business Relationship Communication	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Terminate Business Relationship	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					

[1] The MITA Framework does not define Business Relationship Management at the process level-- only the functional level.

Business Process	Level 1 Business Capability	Level 2 Business Capability	Level 3 Business Capability	Level 4 Business Capability	Level 5 Business Capability	Rationale for "AS IS" Capability Designation
PROGRAM INTEGRITY MANAGEMENT[2]						
Identify Case	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage Case	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
CARE MANAGEMENT[3]						
Manage Medicaid Population Health	Colorado does not perform this process at this time.					
Establish Case	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage Case	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					
Manage Registry	"TBD" – Business Capabilities not Defined in MITA Framework 2.0					

[2] The MITA Framework does not define Program Integrity Management at the process level-- only the functional level.
[3] The MITA Framework does not define Care Management at the process level-- only the functional level.

Appendix C – Templates

Appendix presents the templates used to facilitate the capture of information during the MITA Assessment meetings with Department staff. The templates include the Agenda and the Assessment Session Results Document.

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA

Functional Area

Assessment Session ID:	
Session Date/Time/Location:	
Date Updated:	

Participants:

Name	Role

PROCESS:

Process Description:

Current Process Deficiencies, Workarounds, etc.:

Any information regarding process deficiencies in meeting business needs and any workarounds used to supplement current automated processes required to meet the business need.

Known Policy, Legislative, or Other Impacts to the Current Process:

Any pending policy, imminent legislation, or other initiatives that will impact the current process and the impact the change will bring to the current process.

Policy, Legislation, Initiative	Short Description	Impact to Process

Interfaces and Other Independent "Medicaid" Systems:

Information regarding interfaces or external systems (including user-maintained spreadsheets) used to access information necessary for the completion of each business process.

Interface / External Systems	Purpose

Current Business Capability:
Using the MITA Framework 2.0 Business Capability Matrix, participants will determine the maturity of each target process.

Level 1	Level 2	Level 3	Level 4	Level 5
• .	• .	• .	• .	• .

Please refer to detailed matrix for process.

Maturity Level:
What level of maturity represents the current Colorado process? - Level **X**

Rationale:
Why is the current Colorado process at that specific level of maturity?

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Functional Area

Assessment Session ID:	
Session Date/Time/Location:	
Date Updated:	

Participants:

Name	Role

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE

PROCESSES REVIEWED IN SESSION:

PROCESS:

Process Description:

Current Process Deficiencies, Workarounds, etc.:

Any information regarding process deficiencies in meeting business needs and any workarounds used to supplement current automated processes required to meet the business need.

Known Policy, Legislative, or Other Impacts to the Current Process:

Any pending policy, imminent legislation, or other initiatives that will impact the current process and the impact the change will bring to the current process.

Policy, Legislation, Initiative	Short Description	Impact to Process

Interfaces and Other Independent "Medicaid" Systems:

Information regarding interfaces or external systems (including user-maintained spreadsheets) used to access information necessary for the completion of each business process.

Interface / External Systems	Purpose

Current Business Capability:
Using the MITA Framework 2.0 Business Capability Matrix, participants will determine the maturity of each target process.

Level 1	Level 2	Level 3	Level 4	Level 5
• .	• .	• .	• .	• .

Please refer to detailed matrix for process.

Maturity Level:
What level of maturity represents the current Colorado process? - Level **X**

Rationale:
Why is the current Colorado process at that specific level of maturity?

Manage Health Services Contract: Business Capabilities

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

Appendix D – Session Results

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Member Management

Assessment Session ID:	ME01
Session Date/Time/Location:	July 17, 2007 1:00 – 3:00pm PK Offices
Date Updated:	July 27, 2007

Participants:

Name	Role
Steve Nelson	Managed Care Supervisor
Nathan Culkin	MITA lead and claim FFS Supervisor
Diane Dunn	Claims Section Manager
Cynthia Oten	Not Present
Dan Rodriguez	Client Side
Keith Clay	Project Manager

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Steve Nelson	July 27, 2007 (default)
Nathan Culkin	July 27, 2007 (default)
Cynthia Oten	Not Present
Dan Rodriguez	July 27, 2007 (default)
Diane Dunn	July 27, 2007 (default)
Keith Clay	July 27, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Determine Eligibility
Enroll Member
Inquire Member Eligibility

PROCESS: DETERMINE ELIGIBILITY

Process Description:
The Determine Eligibility business process receives eligibility application data set from the Receive Inbound Transaction process; checks for status (e.g., new, resubmission, duplicate), establishes type of eligible (e.g., children and parents, disabled, elderly, or other); screens for required fields, edits required fields, verifies applicant information with external entities, assigns an ID (already assigned), establishes eligibility categories and hierarchy, associates with benefit packages, and produces notifications .

NOTE: A majority of states accept the designation of eligibility from other agencies (SSI, TANF, SCHIP, other), in which case this business process will not be used by the Medicaid agency for those individuals. In these situations, Medicaid receives and stores the member information sent from other sources in the Member Registry. This may require conversion of the data.

However, this process will be used by the other states which require the TANF, disabled, elderly applicant to apply for Medicaid, and where the Medicaid agency determines eligibility for state-only programs.

Colorado Variations:

- In Colorado, CBMS does a lot of the verification of applicant information with external entities out of the benefit management systems. HCPF brings in the transactions, etc.
- The ID's are already assigned.
- The notifications are done by CBMS.

Current Process Deficiencies, Discrepancies, Workarounds, etc.:

1. CBMS is a shared system with DHS. DHS only determines food assistance (food stamps) and cash assistance (TANF). HCPF runs the medical eligibility assistance section.
2. Regarding conversion, HCPF did not receive request for money that would allow them to use CBMS values. They have to translate the information into MMIS values. Translation is done in the med spans area before it is passed to the MMIS. It then goes through a smush (merging process) process. MMIS receives the integrated data. The program hierarchy is based on legacy values.
3. A more efficient process would come about if MMIS was written to match the CBMS values.
4. When data must be corrected in MMIS, it must go through CBMS – those doing the corrections in CBMS do not always understand of the reasons for the corrections. MMIS functions as the payment system. CBMS functions as the records holding system. When there are discrepancies, lots of questions are asked about why information is not there and how to get the client adjusted.
5. There is an override function in CBMS that is not utilized very much. When things need to be forced through, overrides stay within the business rules that they have. EOMB must be provided for certification of MMIS, but if there is not an address, they can't send it. The business rules are used to make corrections.
6. A weekly review makes sure that the correspondence between CBMS and MMIS clients is carefully monitored. If data is in MMIS and not in CBMS because of a flaw, there is a manual work around in which client data is physically adjusted. Weekly reconciliation. There is also a monthly manual workaround that they do closure on (~200 are done per month). There is a specialized program that is run outside of the normal process. The program run is prompted with a transmittal from HCPF to DHS.
7. The fluke is that a client can be made retroactively ineligible in CBMS. That is not supposed to happen unless they are put on a new case. When an eligibility span is eliminated, there is nothing to send to MMIS to update the span.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
SB 07-002	Foster Care eligibility up to age 21.	Bills will be marked with a new program aide code so that they can track them later in MMIS. This supports a reporting function that will update the loading of client information to MMIS and the valid value list.
SB 07-097	Tobacco Settlement	Increases Child Health Plan Plus to 205% of FPL – there will be additional eligibles. This will be

		marked for reporting.
SB 07-211	Presumptive Eligibility (not sure this is the name).	Presumptive Eligibility is determined for pregnant women, children and CHP+. This process reinstates the codes that mark clients as presumptively eligible.
CBMS Re-procurement	Transfer and Take Over	This will be the same system with a potentially new vendor. More of the systems programming responsibilities will be put into the vendor contract than what they have right now. The batch processes are built by EDS and the decision table rules are done by state workers. This is an opportunity to use a vendor rather than state resources. There are about 82 enhancements for CBMS and MMIS.
	Federal Cap for SCHIP	
	Allowing DSH to bill federal government for additional monies.	

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Nightly, there are 2 eligibility interfaces (case and client).	Loading Eligibility to MMIS.
Monthly, monthly medical extract.	Loading Eligibility to MMIS.

Current Business Capability:
Maturity Level: Level 2

Rationale:

- There is not a "No Wrong Door" initiative.
- They do not enable consumer driven healthcare.
- Is there any potential for data loss in the Smushing process? Maybe.
- If the system loses information somewhere in there, an assumption is made. The workers could go back to CBMS support system to try and find the missing information.
- Cash, Food, and Medical benefits are all determined in the same system through CBMS.
- Child support enforcement is outside of that. If they don't qualify for the medical programs, there is another medical assistance program that is determined by the medical providers (state only program).

- Data verification is completed when a client brings in a birth certificate. The worker then looks at it and manually selects the box on the system. HB 06-S1023 is the state's answer to being able to prove lawful presence. (DRA, 1023, some for one and not the other). Making the two work together is challenging.
- There is not a Spend Down.
- There is a single purpose application (SPA)
- They are permitting more flexibility within the benefit package. This is a matter of their medical condition.
- There are Presumptive Eligibility and Medical Assistance sites with accessibility.
- The decision tables, EDBC, determine what they are eligible for. The state has approved this machine and is approving the eligibility via the non-traditional workers – at schools and at health care sites. These people and the future workers don't have to know the rules; they just have to enter the information.
- Applicants cannot initiate applications from home that easily other than the mail-in for CHP+ - however, the structure is there.

PROCESS: ENROLL MEMBER

Process Description:
The Enroll Member business process receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (e.g., managed care, HIPP (Health Insurance Premium Payments) loads the enrollment outcome data into the Member and Contractor Registries, and produces notifications to the member and the contractor. Either the Agency or enrollment brokers may perform some or all of the steps in this process.

Notes:
In Colorado, HIPP is the HIBI (Health Insurance Buy-In) waiver.

Colorado does have an enrollment broker, but it is for Medicaid only. CBMS does CHP+ enrollment into managed care.

Current Process Deficiencies, Workarounds, etc.:

1. HIBI (Health Insurance Buy-In) identifies clients with 3rd party insurance and high cost of services. Might save money if can buy insurance premium for them. Then, it works directly with the client to enroll them or their insurance program as a provider in MMIS. A transmittal must go over to set up client and insurance in MMIS. Once a month, a premium package for every client is sent over. There are 4-5 methodological steps to follow depending on what the client needs. Individually driven, but exceptionally high demand on the workers.
2. There is a spreadsheet for CHP+ of people who should have been enrolled. People have been being paid based on the spreadsheets. Integration resistance exists. Enrollment resistance (real-time basis not passed) exists also. Enrollments that were built by CBMS through the smush process didn't match. Now enrollments go through a separate check. The enrollments are cut and fit to match the system. If there are only 4 months eligibility, then there are only 4 months of enrollment. This information is loaded into a table directly after checking for certain rules, but a disconnect exists due to the flaw in CBMS. They are missing 4000 enrollments. Of these, only 2000 are explainable, leaving 2000 that are unexplainable. Flaws exist within the system generated pieces. The Maximus process works. CBMS is a little less efficient and the reconciliation is not there.
3. Has **manual override** capability on almost everything – not CHP+ - mostly on Medicaid side. Retroactive enrollments. Can take it away for managed care (BHO goes retroactive after 6 months).

Medical plans are prospectively enrolled. CHP+ - enrolled in states network as of date of application. Prospectively into medical and dental plans (carve out). A couple a day would be maximum on a big day. Only one staff person responsible.

4. Medicaid side has Maximus – enrollments, disenrollments, based on CBMS, input to Maximus, input to HCPF – apply to PHP – the system treats that as an enrollment and has the same architecture – come via interfaces, system, and the manual processes – e.g. If a client is enrolled and the eligibility segments don't match up, there are issues around making that right.
5. CHP+ – does enrollment and uses some of own systems, but ACS is the eligibility determination contract. CBMS does the enrollment. Applications – use some of own systems to track the data. Use CBMS to do enrollment part. MMIS knows about it through CBMS via the enrollment interface (used only for CHP+).
6. MMIS does create enrollments for behavior health organizations.
7. MMIS creates eligibility for Managed care for HMOs – sends information to Maximus and says "enroll if you would like" Maximus takes phone calls and does direct data entry into the MMIS. Maximus knows who will be eligible and does entry. Manual directly into MMIS. Maximus has access to MMIS.
8. Lock-in spread sheet – the MMIS supports lock-in to the degree that you can have 1 primary care physician, other providers (within a limited range), and a pharmacy. Regarding managing clients, if a client retroactively has to change lock-in information (spans, and ids) – these have to be done manually. There have been system changes to alter the spans and a general decline in the number of lock-ins (empty position for a couple of years). As the system works, it's not designed to be a flexible environment (there will be exceptions), so there are anomalies to the system, but the system does not adapt. 25 clients on lock-in. Doing all of this for them. Total there are about 442,000.
9. Waivers – done in 2 ways. Called either determine eligibility or service limitations. If a client is eligibility for HCBS – it's considered long term care – CBMS says that once the client is involved in a waiver, the technician receives a paper that declares eligibility for SSI and long term care. Gives the client an additional marker on their file. Services are paid on prior authorization – when the PA is put into the system, that's when the services are paid, regardless of whether the eligibility system carries the marker. Doesn't' matter if have PA unless 300% eligible. Can provide Medicaid and LTC to client over standard of need and less than 300%. Only way to become eligible is to enroll in this waiver. PA has to be there in order to pay claim, but Medicaid eligibility has to be determined in order to enroll in waiver.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
SB 07-211	Presumptive Eligibility	Enrollment side for CHP+ - a change to mark clients that way.
SB 07-097	Allocate Tobacco Settlement Monies	Poverty level code – determines rate cells.
		Continuous enrollment change from 2 months to 6 months (Medicaid).
		Moving CHP+ enrollment building from CBMS to MMIS to synchronize with CHP+ administrative contract – huge! Client still must choose HMO to determine eligibility. Won't give span, MMIS will have to build a span around it. The data will be better because MMIS will be

		better with the data than CBMS – commercial enrollment and dental.
Budget Amendment	CHP+ at Work	A new program to provide premium assistance to clients who have employment sponsored insurance. Applied for at CBMS and MMIS has to make the payment. Apply in CHP and create provider record in MMIS. Back and forth.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:
Maturity Level: Level 1

Rationale:

- HCBS is automated, but not integrated with MMIS.
- PAs for nursing facilities come from Dual Diagnosis Management and come electronically, but are not well integrated.
- The PA process is the only way that they verify health information.
- They are still manually applying things.
- HCBS still manually verifies information. Managed care does not.
- Enrollment is different from person to person. The outlines and stuff like that change. Clients get to choose. The choices are automated, but what the client does in response are not.
- CHP+ has a choice of 5 plans.
- Maximus has an interface that they use to create paper applications.
- CHP+ has applications that are mailed to ACS CHP.
- No separate application process is necessary.
- Staff size is moderate. They are on contract but they don't have that many people and have lost funding.

PROCESS: INQUIRE MEMBER ELIGIBILITY

Process Description:
The Inquire Member Eligibility business process receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process, which generates the outbound Eligibility Verification Response Transaction. This transaction will, at minimum, indicate whether the member is eligible for some health benefit plan coverage under Medicaid, in accordance with HIPAA. This transaction may include more detailed information about the Medicaid programs, specific benefits and services, and the provider(s) from which the member may receive covered services.

NOTE: This process does not include Member requests for eligibility verification. Member initiated requests are handled by the Manage Applicant and Member Communication process.

Current Process Deficiencies, Workarounds, etc.:
Any information regarding process deficiencies in meeting business needs and any workarounds used to supplement current automated processes required to meet the business need.

1. HIPAA standard transaction has CSRs in process to change things. They are moving to make the state only programs and to upgrade messaging capability. Old Age Pension is the only state program. If they got the 271 back, it would show you that the client is Medicaid eligible when they are not. OAP needs to say OT instead of MC.
2. Messages around those are going through an upgrade right now. Methods of inquiry are working. They include the following methods: interactive through web portal, batch process through web portal, batch process submitted to host server, automated voice response system with a fax back capability (for eligible clients only), or call provider services.
3. MMIS is the single source for all of this.
4. State only programs include MMIS with 271. CICP (Colorado Indigent Care Program) is the exception. They are not held in any system at all. Not a health care claim that they reimburse on. They are off of a cost report for uncompensated care.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
CBMS transfer		MMIS is source record for this. Only hitting one system, so should not be a big deal.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Web portal looks at MMIS, AVR looks at MMIS,	
Feds allow them to ship off eligibility file and let the contractor charge people to get the information. Chose not to outsource.	

Current Business Capability:
Maturity Level: Level 2

Rationale:

- 270, 271
- NCPDP – for pharmacy it is easier to file claims
- Have AVR web portal.
- Have ADI.
- Integrated records of member eligibility – 271 – managed care enrollment, lock-in enrollment, and resources.
- Immediate responses are made.

- MITA standard interfaces are not developed.
- Exceptions – CMS imposed a date limit – could only go back to 7/17/06 to check eligibility – 1 year limit for access.
- DSHs are allowed to inquire for over a year ago for purposes of Medicare DSH cost report. Question – How is access provided? Now, they allow up to 5 years of eligibility information – providers will talk to vendors (via WebMD/Envoy, E-Scan, GDS (Government Data Services)) about doing cost reports through a specialized batch process through 270/271. This is a proprietary process that vendors wanted to use. It has a limited data set, they change it into 270, it hits the system and comes back as a 271 (functioning as a clearing house transaction).
- CGI would take 3-4 months of programming and the ownership of the software would not be certain. They would have to re-program if that was not granted in 3-4 years.
- DSHs have to wait for the fiscal year to close, 3-4 months to gather bills, put together cost report, send to auditors who then want to test to see if the number of clients is correct, auditors then want to verify (3 years). If hospital disagrees with findings, they can request a re-investigation (4 years).
- Level 3 – access to others – not done.

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Member Management

Assessment Session ID:	ME03
Session Date/Time/Location:	July 19, 2007 2:00 – 4:00pm PK Offices
Date Updated:	July 27, 2007

Participants:

Name	Role
Steve Nelson	Managed Care Supervisor
Nathan Culkin	MITA lead and claim systems section
Cynthia Oten	Eligibility and management
Dan Rodriguez	Training for Eligibility Interfaces. Reviews systems documentation for MMIS
Diane Dunn	Claims Section Manager
Keith Clay	Project Manager
Mark Gray	Business Analyst for Managed Care
Patricia Warren	IT Business Analyst

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Steve Nelson	July 27, 2007 (default)
Nathan Culkin	July 27, 2007 (default)
Cynthia Oten	July 27, 2007 (default)
Dan Rodriguez	July 27, 2007 (default)
Diane Dunn	July 27, 2007 (default)
Keith Clay	July 27, 2007 (default)
Mark Gray	July 27, 2007 (default)
Patricia Warren	July 27, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Manage Member Information
Perform Population and Member Outreach
Manage Applicant and Member Communication

PROCESS: MANAGE MEMBER INFORMATION

Process Description:

The Manage Member Information business process is responsible for managing all operational aspects of the Member Registry, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid. The Member Registry is the Medicaid enterprise "source of truth" for member demographic, financial, socio-economic, and health status information. A member's registry record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services. In addition, the Member Registry stores records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment; the member's covered services, and all communications, e.g., outreach and EOBs, and interactions related to any grievance/appeal. The Member Registry may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information. Business processes that generate applicant or member information send requests to the Member Registry to add, delete, or change this information in registry records. The Member Registry validates data upload requests, applies instructions, and tracks activity. The Member Registry provides access to member records to applications and users via batch record transfers, e.g., for Medicare Crossover claims processing, responses to queries, e.g., for eligibility verification and Operations Management Area, and "publish and subscribe" services for business processes that track member eligibility, e.g., Care Management and Perform Applicant and Member Outreach.

Among the business processes that will interface with the Member Registry are:

- The Determine Eligibility process, which checks the Member Registry for status (e.g., new, resubmission, duplicate) and sends completed member eligibility record to be loaded into Member Registry.
- The Enroll and Disenroll Member processes, which send and retrieve member information relating to these processes, such as member's ability to access providers, and plan and provider preferences
- The Perform Applicant and Member, Manage Provider, and Manage Contractor Communications processes, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring these communication processes to prepare notifications
- The Perform Applicant and Member Outreach, which tracks alerts from the Member Information process about information additions of changes in the Member Information Registry that meet rules requiring provision of outreach and education to the affected applicant or member
- The Perform Applicant and Member Communication process, which schedules the face to face or phone interview, receives an application, or receives a referral: logs in request and prepares a package of eligibility information which is sent to the Determine Eligibility Process
- All Operations Management business processes, e.g., Manage Member Payment, Edit Claim/Encounter, and Authorize Service
- The Maintain Benefit/Reference Information process, which is the Member Registry's source of benefit package information
- The Manage Program Information business process, which consolidates key enterprise data for use in reporting, analysis and decision support
- Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Member Registry for member information
- Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Member Registry

Current Process Deficiencies, Discrepancies, Workarounds, etc.:

1. The state does not capture socio-economic information. The state does take into account financial information, but they do not determine the socio-economic status based on demographic location.
2. Health status information is not kept in the client file. It is kept elsewhere in the system, as the conglomeration of the claims that have been paid. It's inferred as part of the system and based on claims paid.
3. Eligibility and enrollment spans are in two different subsystems.
4. The state offers a customized set of services within a benefit plan.
5. CBMS stores the records about and tracks the processing of eligibility applications and determination.
6. Covered services are inferred. There is data available.
7. Outreach and EOMBs can be associated with what the client receives from the state; however, the state carries a letter on a file that indicates approval. There is not a direct list of what services have been received.
8. An EOMB report does exist. They are not sent to every client, but there is a sample. EOMBs are sent. EOMBs are associated with the provider and are not done for CHIP.
9. The state does not track grievances or appeals. These are not in the MMIS, they are done through CBMS if at all. However, the probability of tracking depends on the type of appeal or grievance. The back of the client letter says "if you wish to appeal, write to the Division of Administrative Law Judges (ALJs)." Appeals and grievances are a part of the Department of Personal Administration. They are manual and outside of MMIS. There is no way to track whether the grievance or appeal was made. The only way they know is when they are notified.
10. There is a registry that stores records for services requested or provided.
11. Reviewing providers are marked or recorded. Client utilization is not necessarily marked. Utilization issues go to the county. If the client falsely declares no assets, the county opens the case. This open case is not marked in the system. The eligibility span will change or go away through CBMS without explanation.
12. Direct member payment is done through HIBI.
13. CO does not do spenddown.
14. Applicant or member information is sent to the registry to add or alter information through CBMS interfaces.
15. Batch record transfers are not generally done. However, batch transfers for eligibility verification are done. Transfers are not done except in a couple of places (COBC and Third party contractors). The transfers are not done for eligibility purposes. Data is transferred, but the records themselves are not uploaded.
16. There are some pieces belonging to the state where the information goes out to the clients.
17. Medical home is centered more around the provider and not the client. Right now, the client is not marked.
18. Non-citizen refugee assistance offers assistance to a certain type of refugee. It is tracked by DHS.
19. The information that is tracked is tracked in terms of eligibility groups. State-only clients have a similar tracking process as the other clients.
20. CHP+ spreadsheet exists.
21. Lock-in spreadsheet also exists.
22. Presumptive eligibility clients in Medicaid are another set of clients that we do not know much about. Presumptive eligibility could not be re-put into CBMS, so the state contracted with BCBS to do the presumptive eligibility span work. The application date is the date of the walk into clinic. The clinic receives payments from Anthem. Medicaid also pays. Sometimes there are duplicate payments because information is in 2 systems and the workers are unable to cross-check.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Colorado Cares Prescription	CCRx	A group of clients will exist that

Drug Discount		they will not be able to track by MMIS or CBMS because they are tracked by an external contractor. They will end up doing the service provision by mail and the applications as well. This is a whole group of clients that the state will not know much about, but that are under the purview as a department. There is nothing set up to get the information from the contractor. The question will be as to whether they can do a cross-program tracking. Clients would only do this if they were not aware that they were eligible for Medicaid.
SB 07-002	Foster care to 21	See ME01
SB 07-097	CHP+ 205% of FPL	See ME01
SB 07-211	Health Care For Children	Presumptive Eligibility for pregnant women, children and CHP+ - reinstating codes that mark clients as presumptively eligible.
	Tobacco tax to fund SCHIP	
	Federal cap on SCHIP	

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
COBC	Coordination of Benefits Contractor – the Medicare programs all go through a single clearing house where a file of clients is sent periodically. They match on health insurance claim number and if the number is on the state's list then they send the Medicare claims so they can finish paying them. The cross-over contractor is GHI.
CBMS eligibility interface that hits the registry.	Enrollment that comes over from CBMS daily (business days only). Nightly, there are 2 eligibility interfaces (case and client).
Recovery contractors	Inbound (HWT (Health Watch Technology) and HMS (Health Management Systems)) are the recovery contractors. They get client information to support their efforts.
CHP+ spreadsheet exists	
Lock-in spreadsheet also exists.	

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Extended by workarounds to meet needs – yes.
- Rules based validation and data reconciliation – yes.
- Audit trails – yes.
- Integration with FAMIS – yes.
- Member updates are timely – yes, for the most part.
- Automated updates made to individual files – yes.
- Automatic processing of updates – yes.
- Less staff – yes.
- Premiums are paid on a monthly rate per the policy except the behavioral health organizations which go back to the first date of eligibility. Then, the first month can be pro-rated. Managed care pays for the entire month even if the client is only on for a couple of days.
- Automation improves the accuracy of validation and reconciliation and makes timely and accurate data available. Enrollment of rosters, etc.
- "No wrong door initiatives" – they can go to any state office and get service. Providers in all counties except maybe Eagle Co. have this initiative in effect. Requesting clients must be resident of the county, but they can go to any state office and apply for Medicaid.
- Technology support is provided by service oriented architectures and rules engines. The web portal is service oriented but not all is a classic rules engine because it is not user maintainable. The state still has to have a fiscal agent.
- The centralized registry is not entirely integrated. There is eligibility stuff at CBMS that HCPF doesn't maintain.

***Changed Business Capability Level to Level 1– based on State Self-Assessment Guidelines released by CMS after the meeting was held indicating "Must meet all criteria of the level". Capitated premiums are paid monthly rate not a on a daily rate and only the first month can be pro-rated.**

PROCESS: PERFORM POPULATION AND MEMBER OUTREACH

Process Description:

The Perform Population and Member Outreach business process originates internally within the Agency for purposes such as:

- Notifying prospective applicants and current members about new benefit packages and population health initiatives
- New initiatives from Program Administration
- Indicators of underserved populations from the Monitor Performance and Business Activity process (Program Management).

It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and the State Children's Health Insurance Program (SCHIP). Outreach information is developed for targeted populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction and the

Manage Business Relationship Communication process. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.

NOTE: The Perform Population and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues. Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bidirectional communication.

Current Process Deficiencies, Discrepancies, Workarounds, etc.:

1. EPSDT – case management agencies get the lists of clients who are newly eligible. This is generally county based, though some are regionally based.
2. SCHIP – there is a marketing program that is putting up television ads. There is a call in on Channel 7 next week. Great efforts are being made toward marketing and outreach to the public. There is member outreach with a new member packet.
3. Unless a client enrolls with a managed care program, there is not a welcome effort. MCO are the ones that handle the welcome effort for those clients that enroll with their plan. There is spill over from CHP+, but no other real welcome to Medicaid. They get HIPAA privacy notice and the "you are approved form" and a nice card.
4. All outreach communication is tracked and archived according to state archive rules. EPSDT is maintained on the MMIS. Is any other outreach campaign tracked? The department does track that – e.g. the CHP+ marketing specialist knows how much time is bought for the marketing.
5. Number spike for CHP+ (concerning because there is a cap) there is a predictable spike in Medicaid clients when a marketing campaign is going on. However, there is not a coordination of effort there.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
CHIP funding legislation	Federal legislation to continue to fund the SCHIP program.	Unclear how CHP+ will be funded if Congress does not pass a funding bill.
	Governor's executive order that you don't have to provide citizenship to be eligible for CHP+	
HB 06-S-1023	CO response to DRA 05 – conflicting documentation requirements. There are pieces of HB 1023 that affected CHP, but not in the DRA. Didn't have to prove lawful presence if under age 18, but our program goes up to 19. There was a legislative correction saying that if under age 19, you don't have to prove lawful presence.	
Colorado Promise	Governor Ritter's campaign	He identified 477,000 uninsured

	platform	in CO – as much or more than are under Medicaid. How to address? Join a multi-state cooperative (Preferred drug list) – negotiating rates – de facto multi state programs. We don't buy the drugs, we purchase them from pharmacies. Fixing CBMS? Moving toward universal healthcare or access to healthcare? How is this defined?

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Coordinated among programs.
- Manual – paper or phone, but there is some electronic work.
- ID of targeted members based on member records.
- Sporadic outreach that is not well documented.
- There is some analysis done on un-insured.
- Hard to locate based on programs.
- There are bilingual programs (Spanish or English), but not Russian or Vietnamese or Hmong
- Difficult to maintain consistency.
- TB and Radio stuff for CHIP is there for level 2.
- No kiosks (yet).
- Manual process. Takes the time it takes.
- Material preparation is clunky.

PROCESS: MANAGE APPLICANT AND MEMBER COMMUNICATION

Process Description:

The Manage Applicant and Member Communication business process receives requests for information, appointments and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.

NOTE: Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, i.e., bidirectional communication. Also included are scheduled communications such as Member ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and

appeals. The Perform Applicant and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues.

Current Process Deficiencies, Workarounds, etc.:

1. Receive requests for information, appointments, and assistance from prospective and current members – CBMS has a way of scheduling appointments and files to send out redetermination packages.
2. Process for sending out materials is done by CBMS. There is a marker that indicates that they should send the package out 60 days in advance and the reminder out 45 days in advance.
3. Unclear how clients receive information on their benefits. There is not a place that they can find that out. The information is provided through the primary care physician. Health insurance package allows you to see the limitations more than anything else. Medicaid is the stop gap/loss coverage for everyone. There are so many benefits. There are some limitations that will be overridden by a PA. Chiropractic care is not covered. All else is ok.
4. Medicaid is not advertised because it is expensive. However, there are people who need it and preventative care would be ideal. The providers need to be trying to help people figure out if they are eligible. They are the extended arm to promote care.
5. If someone is eligible for Medicaid and they don't know things, we should have a chart/handout for what is covered and what needs PA.
6. Scheduled communications: Member ID cards, formal communication, grievances and appeals (not done through MMIS – maybe in client correspondence).
7. Paper cards were the form of communication. When they went to the plastic cards, they lost one primary form of communication with the clients – now; they don't know when people move, etc. True for providers as well because the direct deposit prevents them from finding information.
8. EBT card (Quest card) is a cash card that works as a debit card for food services and cash back if they have the cash benefit.
9. Is there anything that is tracked manually regarding communication? CHP+ sent out their first ever member newsletter last month. Had to get addresses from CBMS decision support system in order to send out member notices. No way in MMIS to create labels for clients – only for providers.
10. Medical service questionnaires – under member communication – a diagnosis based system. If get a diagnosis code indicating an accident by the client, send out a questionnaire regarding their plan for recovery (will they get a lawyer, etc?) Attorneys are required to participate.
11. Is anything tracked in the system? TPL? NO. They do have copies of the questionnaires sent out and of the EOMBs sent. You have to search the state ID to see if anything was sent. Uncoordinated.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Colorado Promise	Governor Ritter's campaign platform	Purpose to get more information to clients
Client Web Portal	Web Portal	Purpose to get more information to clients.
Client Survey	Survey	There may be one in the works, but there is not a clear manner of notifying people of the findings.
Client Advocacy	Client advocacy groups	NEED TO WORK ON THAT… a good place for growth. There are a couple of home health agencies who are dedicated to self-sufficiency. Using the 1960s

		model of civil disobedience. Home health agencies sponsor other groups. Information is funneled through the providers and not the clients directly.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Uncoordinated.
- Not systematically triggered.
- Not always linguistically appropriate.
- Incorrect or lack of contact information.
- Non-standard formats.
- Inconsistent and manual responses.
- Delayed responses.
- Medical ID card is somewhat automated. FDP to contractor daily such that it arrives to client about three days after eligible. Three day delay!
- The biggest problem is in pharmacy services because they are usually urgent and the state cannot move forward without a state ID.
- Do not have a client portal yet – but there is a plan to integrate one. There would be ideally a secured area for providers, a secured area for clients, and public information. Need good partners for this portal to come to fruition.
- Maximus is interested in maintaining and expanding their role. The redetermination date is sent such that they can send another package that encourages enrollees to redetermine eligibility.
- We don't know if a member can call in and determine if they are covered or if they have pharmacy access and/or prescriptions filled.

Public Knowledge LLC
Management Consultants

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Provider Management

Assessment Session ID:	PM01
Session Date/Time/Location:	July 18, 2007 1:00 – 3:00pm PK Offices
Date Updated:	July 27, 2007

Participants:

Name	Role
Peggy Beverly	Provider Subsystem and Claims System Information
Nathan Culkin	MITA lead and claim FFS Supervisor
Diane Dunn	Claims Section Manager
Timothy Maloney	operations side, he handles enroll provider and ensures data integrity related to provider information
Keith Clay	Project Manager

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Peggy Beverly	July 27, 2007 (default)
Nathan Culkin	July 27, 2007 (default)
Timothy Maloney	July 24, 2007
Diane Dunn	July 27, 2007 (default)
Keith Clay	July 27, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Enroll Provider
Manage Provider Information
Inquire Provider Information

PROCESS: ENROLL PROVIDER

Process Description:

The Enroll Provider business process is responsible for managing providers' enrollment in programs, including – gathering information into the system.

- Receipt of enrollment application data set from the Manage Provider Communication process
- Processing of applications, including status tracking (e.g., new, resubmission, duplicate) and validating application meets state submission rules, e.g., syntax/semantic conformance
- Validation that the enrollment meets state rules by
  - Performing primary source verification of verifies provider credentials and sanction status with external entities, including:
    - Education and training/Board certification
    - License to practice

    - DEA/CDS Certificates
    - Medicare/Medicaid sanctions
    - Disciplinary/sanctions against licensure
    - Malpractice claims history
    - NPDB and HIPDB disciplinary actions/sanctions
  - Verifying or applying for NPI enumeration with the NPPES
  - Verifying SSN or EIN and other business information
- Determine contracting parameters, e.g., provider taxonomy, type, category of service for which the provider can bill
- Establish payment rates and funding sources, taking into consideration service area, incentives or discounts (budget)
- Negotiate contracts with providers
- Supporting receipt and verification of program contractor's provider enrollment roster information, e.g., from MCO and HCBS organizations
- Requesting that the Manage Provider Information process load initial and changed enrollment information, including providers contracted with program contractors into the Provider Registry
- Prompting the Manage Provider Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including:
  - The Capitation and Premium Payment Area
  - The Prepare Provider EFT/Check process
  - The appropriate communications and outreach and education processes for follow up with the affected parties, including Informing parties of their procedural rights
- Perform scheduled user requested:
  - Credentialing reverification
  - Sanction monitoring
  - Payment rate negotiations
  - Performance evaluation

External contractors such as quality assurance and credentialing verification services may perform some of these steps.

Current Process Deficiencies, Discrepancies, Workarounds, etc.:

1. There are other kinds of certifications that depend upon how the providers are licensed. If the provider is certified by the Department of Public Health and Environment (DPHE), they are approved by HCPF to provide services. The certified providers include nursing facilities (certified by Medicare too), all HCBS providers, FQHCs, RHCs, Hospitals, Hospices, and labs (through CLIA). The state uses certification over licensing for certain provider types.
2. The major aspect not covered in the process is that only hospital (including mental hospitals) contracts are negotiated. This is different for each hospital and it can take months. There is a waivered contract (administrative contract – bring back up in contracting meeting (CO01 Contractor Management – scheduled for July 31, 2007 at 1:00pm)) that would function as a template for the whole process, but there is still a different process for each hospital. Otherwise, there is a standard procedure that all must subscribe to.
3. Services contracts are negotiated also.
4. National Provider Data Bank is not checked.
5. Malpractice claims history is not checked.
6. NPI is not verified. However, they are talking to John Padilla about adding NPI verification.
7. They verify the SSN through a W9 and proof of address.

8. Payment rates and funding sources are not done except for those who are certified. Rates exist for all, and are established by the legislature.
9. Workarounds – all of this is manual work – credentialing - not verified that they are board certified. They verify licensure if they are a provider type licensed through DORA (Department of Regulatory Agencies). Once the provider is in system, licensure is updated automatically through DORA. This is done on a set schedule for each appropriate provider type. Some of these reviews are annual and some biennial dependent upon the provider type. Copies of all licenses and certificates are mailed during initial enrollment process, and they require that the information is on file, but not the actual, current license.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Verifying the NPI	NPI verification -	This will allow them to disseminate information. It came out at the end of May – will be effective at the end of July.
SB 07-130	Medical Homes for Children	Create a mark on provider file that says that they are willing to serve as a medical home for children. This may be in place by 01-01-08. It's a first step in a philosophical change – no real enforcement behind it right now.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
DORA	License verification
CLIA	No interface exists, but once a week the state picks up a data dump from CMS. The state takes the information. They are trying to limit the lab to do certain things based on their certification level – they receive 5 levels of certification and don't have the history to check the certification. The interface is received from ACS – via a website database.
Provider application pended spreadsheet	Information is put on a spreadsheet. The information, once received from provider, is tracked back and closed out. On a spreadsheet because there isn't an ACCESS database and tracking isn't supported in the system. If they don't receive the requested information within 60 days, the application is denied and the provider will have to reapply. The spreadsheet allows them to track who has applied. ACS manages the provider enrollment process.
Application for Approval Tracking spreadsheet	Ensures that applications sent to HCPF from ACS for approval are not lost in the process.

Current Business Capability:

Business Capability Level: Level 1

Rationale:

- Do not have web based applications yet. However, the application is on the web and you can download it from there and print it out and send it. The automation price was out of the budgetary limits.
- Business rules – The ID is automatically assigned. Rates are manually computed. They don't have automated systems for the credentialing. Providers are enrolled timely, but the accuracy is somewhat reduced (there was a lot of turnover this year).
- 2 applications – one for services and one for rendering. Dental was combined. Rendering was created. There is still a ton of documentation requirements for them, but the application is all the same. The pharmacy application is gone.
- Performance measures tracked relating to enrollment include operational statistics – number of applications coming in, number changed by transmittal, etc. There are manual counts on this, but they do have automatic tracking capability.
- Before and after image audit trail is available.
- Level 1: Staff receives and processes business rules. Decisions may take several days (5), but do comply with federal rules. 3 people work on this at ACS. Application information is manually validated when validated at all.

PROCESS: MANAGE PROVIDER INFORMATION

Process Description:

The Manage Provider Information business process is responsible for managing all operational aspects of the Provider Registry, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid.

Colorado Variation *- Not happening.* The Provider Registry is the Medicaid enterprise "source of truth" for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The Registry includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services.

Colorado Variation - *This is tracked in paper folders on the share drive. Pretty manual if done. (requested manually if done at all).* In addition, the Provider Registry stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and all communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal.

The Provider Registry may store records or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management. ***Colorado Variation:*** *No network development is done (they are not recruiting people to come work for them for extra money or that they would encourage people to be exclusive for them). This is trying to correlate provider information with the member information.*

Business processes that generate prospective or contracted provider information send requests to the Member Registry to add, delete, or change this information in registry records.

The Provider Registry validates data upload requests, applies instructions, and tracks activity.
The Provider Registry provides access to member records to applications and users via batch record transfers, responses to queries, and "publish and subscribe" services. **Colorado Variation:** *do not work with "publish and subscribe" services. The state has Medicaid providers working with them and cannot provide information to any provider doing business with another commercial carrier.*

Among the business processes that will interface with the Provider Registry are

- The Enroll and Disenroll Provider processes, which send and retrieve provider information relating to these processes such as application, credentialing and enumeration review status (not doing this in terms of what they are talking about, but once the information is entered, there is basic information present). They do interact with this process, but not entirely to the level of detail.
- The Provider Support processes, such as Manage Provider Communication.
- All Operations Management business processes, e.g., Edit Claim/Encounter, Apply Mass Adjustment, Authorize Service, and Prepare Provider EFT/Check
- The Maintain Benefit/Reference Information process, which is the Provider Registry's source of benefit package information
- Program Integrity Identify and Establish Case and the Care Management Establish Case processes, which access the Provider Registry for provider information
- Program Integrity and Care Management Manage Repository process, which either stores records or pointers to records relating to these processes in the Provider Registry

Current Process Deficiencies, Discrepancies, Workarounds, etc.:

1. There is not a good provider registry.
2. The provider records and enrollment applications, credentialing and enumeration verification are tracked in folders maintained at the Fiscal Agent. This process is pretty manual if done at all.
3. There are questions about the provider registry and whether or not the registry is referring to member care or to case management.
4. "Publish and subscribe" services do not work with them. The state has Medicaid providers working with them and cannot provide information to any provider doing business with another commercial carrier.
5. Manual process around grievance and appeals is usually performed by HCPF.
6. Communication with providers is done through letters, provider turnaround docs, hardcopy or email, or EFT. Some statuses are tracked, but there is a lot that is manually done. There are active CSRs that will be fixing some of these things.
7. Respite care facilities sometimes have to get new provider IDs. Depending on how they are requested, if you are a nursing facility requesting respite care, you have to get an entirely new provider ID. Only one provider type can be associated with a provider ID.
8. There are problems in the system because of the way that Medicare does business. For example, crossovers do not always work correctly.
9. The intent to retract is contracted. Fraudulent abuse monies are also contracted.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Updates are made on the website within 24 hours or 3-5 days if done on paper
- Updates are automated if done via the web portal or CLIA. DORA must be reviewed manually if our files don't match Dora records.
- Those that are automated are verified for accuracy.
- The data entry staff consists of 3 people.
- Members receive the PCPs automatically.

PROCESS: INQUIRE PROVIDER INFORMATION

Process Description:
The Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.

Current Process Deficiencies, Workarounds, etc.:

1. The web portal has information that is limited to the providers. There is not a way for the clients to look up the providers for the clients. There is an old PDF file from 2003 showing active providers. Information for clients on current, active providers is not available because it has not been determined who would manage it.
2. Provider filling out a claim – would go to find a provider (prescribing, servicing, referring, etc.) – they can find this via the portal. Provider IDs cannot be provided because of HIPAA. They are supposed to get the information from the providers themselves. Someone has to go out to find whether there is a provider in existence.
3. Clients can call the HCPF call center to determine if a specific doctor is a Medicaid provider. Provider can call the provider services call center for this information. There are both manual and electronic ways to get this information.
4. Although they were trying to find someone to manage client access to this information, there have not been discussions concerning this for over 6 months.
5. The state is already loading the information into MMIS. It would be ideal for the website to get the provider information linked back into the web portal via CGI.

Known Policy, Legislative, or Other Impacts to the Current Process:

There is not an initiative to change operability and not any legislative movements going forward.

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Web portal	Specifically for providers – contacts ACS if provider doesn't have web access.
Client services	Have to contact HCPF customer service

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Neither EDI nor AVRS apply. You have to have a provider ID already.

- Responses are not inconsistent or manual. There are not delays. There are immediate, consistent and timely responses.
- Vast majority of providers do not know that the specialty look up exists.

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COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Provider Management

Assessment Session ID:	PM03
Session Date/Time/Location:	July 24, 2007 1:00 – 3:00pm PK Offices
Date Updated:	July 25, 2007 2:00 – 3:00pm PK Offices w/Carol and Vernae

Participants:

Name	Role
Vernae Roquemore	Provider Liaison/ Specialist
Carol Reinboldt	Operations Manager
Peggy Beverly	Provider Subsystem and Claim System Information (Not Present)
Nathan Culkin	Claims Fee for Service Supervisor (Not Present)
Diane Dunn	Claims Section Manager

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Vernae Roquemore	August 3, 2007 (default)
Carol Reinboldt	August 3, 2007 (default)
Nathan Culkin	August 3, 2007 (default)
Diane Dunn	August 3, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Manage Provider Communication
Manage Provider Grievance and Appeal
Perform Provider Outreach

PROCESS: MANAGE PROVIDER COMMUNICATION

Process Description:
The Manage Provider Communication business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via the Send Outbound Transaction process.

NOTE: Inquires from prospective and current providers are handled by the Manage Provider Communication process 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 of appeals. The Perform Provider Outreach process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.

Current Process Deficiencies, Workarounds, etc.:

1. Provider communication (a.k.a. provider relations) – CO has a call center (14 staff members) at the Fiscal Agent who take calls from prospective and potential providers regarding claims, eligibility, issues, etc are answered through the call center. In addition, the Fiscal Agent (ACS) has five provider enrollment staff and a manager for the area,
2. Licensure and certification – if there's a situation, the State staff can step-in and confirm approval. Some have to go to the Department of Public Health and Environment before the staff can do anything. They still have to adhere to policies and rules relating to enrollment. DORA also has some verification responsibility. There are only certain approvals that come to the State themselves. Most have to go through more processes before the State sees them.
3. In long-term care, because there is a variety of providers and their certification requirements are specific, a State staff person is involved to determine that the qualifications and certifications are correct. Ex. If doing a home modification, you have to have permits and licenses, if electrical, have to have enlisted, there are certain qualifications that have to be in place. If home health, there are special certifications for the services. This was held tightly in LTC. Others may be broader. Hospitals, hospices, nursing facilities are licensed. If only certified not licensed, you don't get Medicaid dollars (or Medicare). Still can practice and call yourself a home health agency or personal care provider, but cannot get federal money
4. State directs the Fiscal Agent regarding application or providing guidelines. Tim Maloney put together a document of all the check lists that have to happen.
5. Provider relations call center – most of the information is coming through that. Because related to provider communication, is there information that can come off of AVRS? No. What does come through AVRS is: eligibility, claim status, and warrant – and a 20 second outgoing message for provider services done through a phone triage. When you enter the CO system, there is an initial outgoing message and then there is the ACS commercial.
6. Provider communication grid used from phone message center. Maintaining confidentiality, but providers communicating formally with the State have to use their letter head. There are some electronic provider file updates through web portal. Affiliations, addresses, etc. Largest method of communicating is through the Provider Communication Bulletin. Only 4000 of 16000 providers receive the bulletins electronically through email because they are the only ones that have supplied email addresses. Provider Communication Bulletins are mailed once a month – with some (rare) special bulletin mailings. These are general informative mailings. Examples of what's in the regular bulletin include new program information, rate changes, training schedule, etc.
7. Specialty provider bulletins are targeted at particular provider types, (done for PCR) if they are the ones that need information specific to them.
8. Bulletins carry the force of law: official communication from Department via Fiscal Agent – it's considered policy and if they don't adhere to it, they can be taken to court.
9. There are provider manuals that are available on the website. New providers are sent a CD with a copy of the manual on it. Providers are informed of changes to the manuals via the bulletin. Providers are also responsible for system specifications that are specific to CO.
10. Incoming: provider services call center and provider representatives who are responsible for conducting the training for the providers (2 sets of training each year – in house and state-wide). These are grouped by common interest levels (bills 1500, nursing facilities on UB92, etc). Specialty training sessions are generally conducted in Denver because they are better received that way. When trainers are not out training, they are in house helping with problematic providers, outreach, top 25 billers who have not registered NPIs, and specialty help with providers in other areas (there are 2 field representatives that help with these tasks).
11. Of the 16000 providers, only half are billing, the rest are rendering or referring providers. Of billing providers, many of them have been trained, so they don't need it year after year. The State hopes to move toward online (computer-based) training. Online training is not deployed yet, but they have done the first prototype. Online training deployment will be ongoing and upgraded as it progresses.

12. The Web Portal allows claims submission, eligibility submission, and claim status as well as updates of affiliated providers, (e.g., if a clinic calls the provider number, the address, tax ID are good, they can add an email address). If all doctors are not correct, they can add doctors or remove them and keep entries current. Some provider types cannot add affiliated providers like hospitals and out of state providers. Hospitals cannot change addresses, but they currently can register NPI online. Registration of NPI online is temporary functionality. Hospitals must change address by mail. All providers must change their NPI by mail. Provider messaging: minimal information is available
13. Provider Services Website: available through main Department website: www.chcpf.state.co.us click on link to provider services. "What's New" section also gives out new information. Main page will also have some vital information. Bulletins, manuals, and companion guides are all also online. The Provider Services Website is the main link to providers. It is information for all providers to use at any time. Some have other means of verifying eligibility, but it is at their discretion how they utilize it.
14. Bulletins and communication are tracked (as in how many are sent out). You can see them on the system as well as the numbering system (that has the year and all in there). But it's not indexed or table of contented; therefore it doesn't support searches easily.
15. The Department has extensive interaction with providers – through specialty groups and policy groups (that work with providers). The Department recently provided a list of external work groups and staff groups (e.g., Health plan systems group – managed care plans have systems needs because so much is system oriented, this meeting occurs monthly to answer questions, discuss changes in the systems, etc.) and there are two policy meetings with those providers: DME advisory groups, MAC-D (Medicaid advisory group for people with disabilities). These are all manual processes and are not standardized. Standardization is difficult because they are addressing specific provider needs.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Not this year.	Last year, suppliers had to have a local, CO address unless they got a reprieve from the State indicating that they were the only provider for that service and there was not one in CO.	
Adding a new program or legislation	e.g., Medical homes for children – a flag in provider file that will indicate willingness to do so. Pediatric Hospice Waiver.	This may require additional communication with providers regarding expectations but doesn't change the communication process.
Additional training	How to Bill	This will happen more often when they get closer to new claim forms. New UB04, proprietary CO1500 want to go to CMS 1500, new dental form with NPI, new pharmacy paper claim form, EDSDT will be rolled into CO1500. There will be some system things that have to alter, but the electronic submission won't be altered. PA request forms are also involved in this.

Policy, Legislation, Initiative	Short Description	Impact to Process
Legislation	Tele-medicine	2 legislative bills (one regarding tele-medicine from practitioner point of view and the other one will be in the HCBS side of things – look this up online) that are going to potentially pass – new training, new billing manuals, new everything (new enrollment, application requirements), etc. This will change how communication flows.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Online system	Tracking.
Web portal	Registering NPI/provider data maintenance – this is gathered and batch processed overnight (e.g., you can type in, etc, but the changes are saved for a batch process to apply.)
COFRS (Colorado Financial Reporting System)	Once provider enrollment is completed, the state automatically sends payment record information to state accounting information system. They also perform updates.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Some standardization.
- Some electronic through the web portal and some through call-center.
- Had to staff-up recently because not keeping track of applications.
- Carry roughly 200 pending applications at any given time. There are delays because the providers haven't filled out information correctly.
- Some providers are mono-lingual. Some do not speak English well enough to conduct business.
- There was a debate as to whether there should be a Spanish speaking person in provider services, but landed on the fact that English is the language of business. But, feel that we get along ok.
- Gap in the managed care. Diane's staff does customer service for managed care. She has asked that Provider Services provide the research and answers for why clients show up on some reports and not others. Since it requires system staff to answer questions, the fiscal agent cannot answer the questions, and they have to send the managed care provider to the department for answers.
- Waiver – completed by Fiscal Agent.
- Special providers – completed by department.

PROCESS: MANAGE PROVIDER GRIEVANCE AND APPEAL

Process Description:

The Manage Provider Grievance and Appeal business process handles provider* appeals of adverse decisions or communications of a grievance.

- A grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process.
- The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented.
    - Results of the hearing are documented and relevant documents are distributed to the provider information file.
- The provider is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program Quality Management Business Area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.

NOTE: States may define "grievance" and "appeal" differently, depending on state laws.
*This process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when an application for enrollment is denied.

Current Process Deficiencies, Workarounds, etc.:

1. In MMIS, there is the reconsideration process that is a form on the website that is for grievances (form that allows the complainer (the provider) to complain about payment, timely filing, etc)). The provider can download the reconsideration form from the website, fill it out, and mail it to the Department for processing. This is tracked as a special document type. Grievances are denied electronically and suspended on paper. Edits are set up differently based on the reconsiderations: deny for one provider and pay another, different pay rates, etc. A duplicate of x-rays when a mother is having twins is a good example of when there are special instructions: edits can be forced and claims can be paid (first level appeal). This is a paper process with the claim. Reconsiderations are performed manually and they get batched and keyed in at ACS.
2. If there is no satisfaction at first appeal to AG there is a message that prints stating that the reconsideration is denied and then offers the address for the appeal with a 30 day limit. There is an appeals process with the Attorney General's office which works with Roberta Lopez. The attorney contacts Roberta and the State looks up the appeal and determines what needs to happen. These are often emergency services. If it is something that cannot be fixed or the provider was out of timely filing and it was their responsibility, then they sometimes have to go to court. There may also be a settlement conference (arbitration). If that doesn't work, they go to court.
3. This happens with claims or with provider enrollment problems – if they want to be back-dated, they can appeal it. If they were terminated and don't want to be (even if not billing), this can be appealed. Enrolled without EFT (CO is forced EFT state – electronically forced state. 98% of claims are electronic.) This can be appealed
4. Timely filing and provider enrollment issues are the primary sources of appeals.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Attorney General's office may have something	
Reconsiderations are in MMIS	Paper documents are batched and scanned and tracked that way.
Provider Enrollment	Pended applications can be tracked in the MMIS.
Appeal Spreadsheet	Excel spreadsheet for tracking appeals

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Do use MMIS but this is still a time-intensive process.
- Requests are mailed to AG's office when the appeal is desired.
- No way to file appeal online.
- Documents are scanned. We don't know what happens at the AG's office.
- Most is manual including research.
- It is labor intensive, but usually only 1-2 claims per provider per appeal. Not necessary to automate.
- Volume – 3/month.
- Appeal at AG's office: 2-3 /month
- Reconsiderations – 500-600 claim lines/month. Sometimes one provider wants to appeal a lot.
- 150-200 providers per month – this uses MMIS to track in a standardized method and in decision report system to find things.
- Automated using MMIS, but not AVRS or Web Portal – not electronic. Paper driven submissions.

PROCESS: PERFORM PROVIDER OUTREACH

Process Description:
The Perform Provider Outreach business process originates internally within the Agency in response to multiple activities, e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, or changes in the Medicaid program policies and procedures.

- For Prospective Providers not currently enrolled, provider outreach information is developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers).
- For Providers currently enrolled, information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives.
- Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction.

- All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules.
- Outreach efficacy is measured by the Monitor Performance and Business Activity process.

Current Process Deficiencies, Discrepancies, Workarounds, etc.:

1. Program staff members go to different sections of the state to educate providers.
2. Outreach materials are developed for training. Web portal was developed – this is documentation/teaching tools.
3. Re: NPI – was there electronic correspondence? Yes – some get bulletin via e-mail, but most of it is paper correspondence via the Bulletin. There were notices on provider services website (18 months+).
4. Some training to ACS staff to encourage them to utilize the webportal.
5. Program staff members create a lot of material based on provider data. For example, with the autism waiver, the program representative was to tell them who would be there, what was needed, etc. A billing manual was created. These were developed in response to new programs and legislation.
6. Most outreach is done through currently enrolled providers.
7. Potential providers work is very limited. No campaigns, no marketing, generally not a part of the IT landscape. CHP does have some of these programs. Stop gap – unless the governor has something to say about it.
8. Department is unsure how counties manage problems – this is probably where policy comes in. Outreach is performed through trade associations if working with prospective providers (provider task force).
9. For currently enrolled providers, the majority of information provision is accomplished largely through bulletins – through field representatives and at training sessions.
10. Public health through DHP.
11. (Public Health Alert) PHA – not yet. Comes through DofPHE
12. PCP outreach is performed through targeted mailings – they can get specialty provider labels, but mailed hard copies. There is some communication through the managed care program. There is someone who helps get the information out. This is handled by the department for credentialing, etc.
13. Outbound communication is done through provider claim report (Pre-HIPAA) that is sent electronically through the webportal as is the provider bulletin. A significant amount of communication takes place through the webportal.
14. A Provider survey is conducted annually – got a really good response this year (375 responses). They took a group of e-mail addresses on file CMS (Colorado Medical Society) sends out to other people via their e-mail list. Responses go through survey monkey and are currently limited to the month (this may be opened to more next time because there is a year subscription to survey monkey right now). There is a reminder about the survey sent to the same group of e-mail addresses once a week for 4 weeks. This year 100 or so more responses came in than last year.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Colorado Promise	Providing healthcare for more people	

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
E-mail	There is just one e-mail per provider that has to then

	be forwarded on to correct people. This is hard to keep updated and hard to make sure that the right people get the information provided. There is no assurance of delivery with hard copies, but since they are documented on the website, they have records of timely notice and thereby validation of delivery.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Automation was beyond departmental budgetary ability.
- Perform Provider Outreach to targeted and enrolled providers is not accomplished. Television, radio, etc. are not used to contact providers or potential providers.
- Claims history – done.
- Outreach is coordinated.
- Linguistic and cultural deficiencies among the provider community obstruct provision of care to ethnic and immigrant populations.
- Manuals are manually prepared and updated.
- There is no standard time allotted for manual preparation.
- New pages are posted to the portal – not mailed, though the department can provide a CD.
- There are inaccuracies and inconsistencies throughout outreach materials.
- Information is on website/portal.
- Electronic media is not unanimously preferred.
- Staff develops and maintains materials manually, but they are also maintained on the website. Either edits or Word – track-changes. These are maintained on the website and uploaded on a new version.
- Coordinating track-changes back in time is a tougher project.
- Postal expenses for bulletins have been cut back, but not eliminated.
- Bulletins are mailed. Providers have been asked to volunteer to eliminate use of paper bulletins but this is not happening.
- Department is trying to group providers and clinics by address to avoid sending multiple copies to one location.
- Studies are conducted to see how improvements are made in provider performance and how to improve in outreach education. Department is in the process of trying to understand how to improve performance and deliver information to providers (Carol). Access is not monitored: department does not know which providers are accessing and which are not.

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COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Contractor Management

Assessment Session ID:	CO01
Session Date/Time/Location:	July 31, 2007 1:00 – 3:00 pm PK Offices
Date Updated:	August 10, 2007

Participants:

Name	Role
Diane Zandin	MMIS Contract Administrator
Roberta Lopez	IT Contracts and Monitoring Section Manager
Steve Nelson	
Nathan Culkin	MITA lead and claim FFS Supervisor
Diane Dunn	Claims Section Manager
Laurel Karabatsos	
Jim Coghlan	Procurement Director
Jessica McKeen	
Keith Clay	Project Manager

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Diane Zandin	August 10, 2007 (default)
Roberta Lopez	August 10, 2007 (default)
Jim Coghlan	August 10, 2007 (default)
Steve Nelson	August 10, 2007 (default)
Nathan Culkin	August 10, 2007 (default)
Diane Dunn	August 10, 2007 (default)
Laurel Karabatsos	August 10, 2007 (default)
Jessica McKeen	August 10, 2007 (default)

PROCESSES TO BE REVIEWED:
Manage Health Services Contract
Award Health Services Contract
Close-out Health Services Contract
Manage Administrative Services Contract
Award Administrative Services Contract
Close-out Administrative Services Contract

PROCESS: MANAGE HEALTH SERVICES CONTRACT

Process Description:

The Manage Health Services Contract business process gathers requirements, develops a Request for Proposals, requests and receives approvals for the RFP, and solicits responses.

Health care services include: medical care services, pharmacy benefits, dental benefits, mental health benefits, primary care services, and health care services outsourced to health insurance programs.

Current Process Deficiencies, Workarounds, etc.:

1. It is assumed that these services are direct. The administrative services are not included here.
2. We have two different systems: physical health care and mental/behavioral health.
3. In behavioral health, they have a mental health program where they issue an RFP. There are 5 regions in the state. For each region, they select one vendor to serve that entire region. The clients are enrolled in that BHO. They do a waiver with CMS to be able to do the mandatory enrollment and then they can require that the clients be enrolled. This waives the choice requirement.
4. Preparing for the RFP is a process that they engage in ahead of time to ensure that there are not federal or state regulations. They get stakeholder input and make sure that there are not things that they need. The staff drafts the scope of work.
5. On the physical health care side, they do not currently do RFPs nor do they have a waiver with the feds. Any willing provider is ok for contracting according to the state procurement rules. If the department contracts with more than one vendor in one area, the client's enrollment with a particular provider is voluntary.
6. The staff goes through to ensure understanding of federal regulations, state statutes, etc. They contract with them.
7. In both cases, they define the benefits and requirements, and the rates section sets the capitated rates.
8. The physical health side has HMOs (fully capitated) and prepaid inpatient health plans (PIHP) (not capitated – Fee For Service (FFS) and vendors get per member per month management fee for doing things, like HMO.) They have a Primary Care Case Management program (another CMS managed care program). This is individual providers who contract with them to agree to be the gate keeper for client services. They pay fee for service for these services through MMIS. The rates for the HMOs and the BHOs are developed by the rates section based on how they define the benefits packages. The rates section also helps verify or establish the appropriate PMPM PIHP.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
CO Promise	We are going to attract more managed care	Trying to attract more plans – this will be policy and they are trying to increase the plans according to current practices. There will be increase in plans and clients who are in managed care.
CO Promise	Moving toward universal health coverage	Make policy decisions on whether they want a mandatory physical health program – they will have to decide whether to RFP for certain areas.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Client enrollment information is passed back and forth	This enables them to know capitation payments
RFP posted on state bid system	The web system that is for providers and vendors to access the RFPs – modifications, questions, etc. would be communicated via this system.

Current Business Capability:

Maturity Level: Level 2* see bullet three below.

Rationale:

- They exchange electronic enrollment files with vendors or contractors on a monthly basis so that they can determine which clients are in their plan and ensure that they receive capitation payments for enrolled clients.
- Reporting requirements are satisfied through the use of template reports that contractors submit electronically through an email alias set up at the department.
- *They cannot submit applications via portal though.

PROCESS: AWARD HEALTH SERVICES CONTRACT

Process Description:
The Award Health Services Contract business process receives proposals, verifies proposal content against RFP requirements, applies evaluation criteria, designates contractor/vendor, posts award information, entertains protests, resolves protests, negotiates contract, notifies parties.

Current Process Deficiencies, Workarounds, etc.:

5. This is the responsibility of the procurement process. When the RFP is written, staff develops evaluation criteria. An evaluation committee is created who will ultimately select the winning contractor on the RFP.
6. Once proposals are received, the procurement staff delivers the proposals to the evaluation committee, who then reviews the proposals and compares them to the evaluation criteria. The evaluation committee meets as a group, walks through each proposal, and scores individually. These scores are totaled using an Excel spreadsheet which automatically calculates the raw scores times the criteria weights to determine the final score. The final score determines the winning proposal.
7. Once scored, the procurement office gives a final review, notifies the executive director of the intended award, and issues the award via faxed letters to all proposers and also posts the award on the state's BIDS website. From that point, there is a 7 working day protest period. If no protests are received, the department may proceed with negotiating and executing the final contract.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process

N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Spreadsheet is available for technical scoring	Scoring
BIDS website	The centralized location for display and download of all state solicitations (including RFPs, RFIs and bids). It is the only location for a bidder to download and respond to an RFP. The bidder must subscribe to have access.

Current Business Capability:

**Maturity Level: Level 2 ***though applications cannot be submitted via web portal, all other criteria apply.

Rationale:

- This is a manual process. Receive, read, score
- Proposals are not submitted via web portal.
- Application data is standardized within the state.
- Verifications are a mix of manual and automated steps.
- Decisions are pretty consistent.
- The format is determined and defined.

***Changed Business Capability Level to Level 1– based on State Self-Assessment Guidelines released by CMS after the meeting was held indicating "Must meet all criteria of the level". Applications cannot be submitted via web portal, all other criteria apply.**

PROCESS: CLOSE-OUT HEALTH SERVICES CONTRACT

Process Description:

The Close-out Health Care Services Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.

Current Process Deficiencies, Workarounds, etc.:

1. There is not a formalized contract close-out process in CO, though some agencies may internally have them. For some contracts, they do have a pre-defined transition process. These might be defined in the RFP prior to the transition.
2. Let the contract lapse and the staff responsible for monitoring the contract ensures that they have done the work required for the contract.

3. If terminating the contract before the end of the contract, termination procedures as defined in the contract, must be followed.
4. The contract will generally define steps to take for termination: payments, notifications, documentation transition, etc.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Close vendor out of MMIS for that contract.	Security
Stop capitation payments for that contract.	Financials

Current Business Capability:

Maturity Level: Level 1* see second bullet

Rationale:

- The process is not "sophisticated" or very hi-tech. They notify with letters. Internal activities are pretty basic.
- The criteria on the matrix do not make sense for this process though.
- Contracts are generally paper based due to the need for original signatures, etc. There are electronic signatures, but there are a lot of steps necessary to validate electronic signatures and there is a slim possibility of their having the technology to verify the signatures.

PROCESS: MANAGE ADMINISTRATIVE CONTRACT

Process Description:
The Monitor Administrative Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.

Current Process Deficiencies, Workarounds, etc.:

1. Implement the contract monitoring procedures. Based on the terms of the contract, set up tracking for reports that are needed, performance management, service levels, QA, communication processes, etc. These are not standard throughout the department. There are certain ways of doing them in IT because there are centralized contracts and specific ways of dealing with the groups.
2. CBLTC has a contract that they are not sure of what type of contract it is. Not sure what they set up re: communication, etc.
3. Centralized in IT by a section "IT contracts and monitoring." They write the contracts and work with procurement directly. When contracts are executed, work with the project manager to set up what is needed, monitoring budgets, etc. Work with PM if there are problems.

4. Manage Administrative Contract is the whole gamut for them.

Known Policy, Legislative, or Other Impacts to the Current Process:

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Policy, Legislation, Initiative	Short Description	Impact to Process
SB 228	Database that HCPF is excluded from right now.	
EO 16	Talked about last week.	
Paper	Lots about contract management with CBMS, and other failed projects.	Lots of visibility with past failed projects.
Potential initiatives	Jenny Brown – legislative liaison	

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Budgeting spreadsheet for every contract	Some track the amendments.
MMIS reports monitor performance	
Contractor Reports	
Decision Support System (DSS)	
Complaints from providers	
Service references from other areas	
The complaints are made pretty directly to IT	
Tracking the progress of amendments through the clearance process.	
These are placed on the section share drive not in the open. (specific to IT).	
Amendments are available in hard copy through Jim Coghlan.	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- L1 is time intensive, different formats for different data. CMS messed up in their discussion of applications. However, if talking about provider as contractor, then it would make more sense.
- Administrator: They are all RFP'd by contract, not through application.
- L2 has some standardization.
- There is not really a centralized function. The performance requirements monitored is different across the different contracts. Eg. What Diane Z. collects from contractor 1 is not the same as that she collects from contractor 2. Quality and accuracy are responded on complaint basis. If monitoring system is necessary, they will establish it. They monitor, track, and collect some information as a core data set. There is a specific set of things that are tracked for each contract, some similar and some

different based on the contract. IPS (Medicaid ID card vendor) vs. ACS vs. CGI – the data they want changes based on the contractor.

- There are similar standards held for all of the contractors. However, the way that the contracts are written dictates how they can enforce the contract. That's where the differences come in. Roberta and Diane have developed an SLA template to use the format and the criteria across contracts. This movement toward standardization is slowly happening. Very manual process.
- The contract itself has a model IT template, but most of the time there is deviation from the standard 40 clauses (adding, tweaking, etc). Of the original 40, only about 35 will be the same. Thus, this affects how they monitor because the standard is altered.
- For IT contracts, the performance standards are in the RFP along with the scope of work, the contractor responsibilities, and the state responsibilities. The RFP becomes incorporated by reference. There are other areas that do not do that and write a more specific contract. IT offers what they want and the contract in the RFP.

PROCESS: AWARD ADMINISTRATIVE CONTRACT

Process Description:

The Award Administrative Contract business process gathers requirements, develops Request for Proposals, requests and receives approvals for the RFP, and solicits responses.

Administrative services include: fiscal agent, managed care enrollment broker, professional services review, authorization for services, fraud detection, third party recovery, and many other outsourced services.

Current Process Deficiencies, Workarounds, etc.:

1. This is the procurement process. Jim Coghlan will be able to talk more about this.
2. Diane Z.'s role as contract manager is to work with the project manager, work with the affected work areas, and work with the rest of the department to figure out what they need and help with the writing process (if there is not a vendor to do that). She also works with the vendor and bring it through clearance.
3. Are there standardized processes? There is a standardized process for gaining approval for writing the RFP. The actual RFP has to have approval. The award has to have approval. An executive director is who grants approval.
4. There are some standardized processes on how they choose an evaluation committee.
5. There is not a standard RFP template. There is a standard model contract (boilerplate). All RFPs look different within the department.
6. Whether or not there are movements toward standardization is not something that Diane is aware of.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

- **Maturity Level: Level 1**

Matrix definitions do not appear appropriate for Award Administrative Contract process. (copy of matrix for Manage Administrative Contract process)

Rationale:

Mostly manual

- Standardization is low.
- No standard process for collecting information.
- Enrollment brokers would have to speak for themselves.
- There is a "habit" of contracting the other areas that are going to be affected by a contract. Will contract eligibility operations and policy for when it's time to reprocure CBMS, etc. Ask for input, requests, additional services, etc. However, this is not a SOP. It is a "best practice habit."

PROCESS: CLOSE-OUT ADMINISTRATIVE CONTRACT

Process Description:
The Close-out Administrative Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.

Current Process Deficiencies, Workarounds, etc.:

1.
2.
3.
4.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process

Interfaces and Other Independent "Medicaid" Systems:
Information regarding interfaces or external systems (including user-maintained spreadsheets) used to access information necessary for the completion of the business process.

Interface / External Systems	Purpose

Current Business Capability:

Maturity Level: Level X

Matrix definitions do not appear appropriate for Close-Out Administrative Contract process.

Rationale:

- When contract ends, Diane makes sure documents are all together and prepares them for archive. Ensuring that the contract fulfills requirements, that the deliverables are delivered and acceptable, etc. Beyond that monitoring, there is not an amendment that closes out the contract, there is not a performance evaluation, the contract just "goes away."
- There is not usually a close-out conference. When Blue Cross ended, there was a close-out part of the RFP. There is a transition turnover type of thing. There is usually a project plan associated with the turnover that the outgoing and incoming contractors will do, and that the department will do. (This was not necessary with the reprocurement because they kept the same vendor). IPS is a new vendor. DOIT (Division of IT services) produced the card until about 3 years ago; therefore there was never a need. CGI is a new contractor for the web portal too. Anthem to ACS was the only time that the transition occurred. 1996 the development started and in 1998 the transition completed.
- Smaller contracts might have a more direct close-out effort. (HIPAA might be a good example of a close-out process.)
- Warranty is a contract based concern. This is not usually included in contract close-out.
- There is a desire for a contract close-out meeting, but there has not been a definition yet.

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Contractor Management

Assessment Session ID:	CO03
Session Date/Time/Location:	July 25, 2007 10:00 – 12:00 PK Offices
Date Updated:	August 3, 2007

Participants:

Name	Role
Diane Zandin	MMIS Contract Administrator
Roberta Lopez	IT Contracts and Monitoring Section Manager
James Coghlan	Procurement Director
Carol Reinboldt	Fiscal Agent Operations Manager

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Diane Zandin	August 3, 2007 (default)
Roberta Lopez	August 3, 2007 (default)
James Coghlan	August 3, 2007 (default)
Carol Reinboldt	August 3, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Perform Potential Contractor Outreach
Manage Contractor Communication
Support Contractor Grievance and Appeal

PROCESS: PERFORM POTENTIAL CONTRACTOR OUTREACH

Process Description:

The Perform Potential Contractor Outreach business process originates initially within the Agency in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures.

- For Prospective Contractors not currently enrolled, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs.
- For Contractors currently enrolled, information may relate to public health alerts, public service announcements, and other objectives.
- Contractor outreach communications are distributed through various mediums via the Send Outbound Transaction.
- All contractor outreach communications are produced, distributed, tracked, and archived by the agency according to state archive rules.
- Outreach efficacy is measured by the Monitor Performance and Business Activity process.

Current Process Deficiencies, Discrepancies, Workarounds, etc.:

1. Sometimes the vendor alerts the state to information and vice versa.
2. Much of this is legislative driven – but the legislation may leave it open to the Department depending on the situation. The Department's outreach is dependent on the legislature's decisions but outreach efforts are made to whichever vendor(s) is affected by the legislation.
3. For the MMIS Fiscal Agent, there are meeting minutes for certain meetings, email records. Anything official is on a transmittal and tracked. Daily transactions are not necessarily tracked. Sometimes there are minutes generated, but not always. These meetings generate project plans, change request documents, spreadsheets that track amendments.
4. Official directions given to the Fiscal Agent contractor are tracked via transmittal. There is other supporting documentation as well.
5. New contractor or new procurement – as for identifying potential bidders list, are the communications tracked or monitored? Is the announcement tracked or the posting documented? They rely on program staff or IT to send out the announcement as widely as possible without targeting specific people. This is not a consistent procedure.
6. Whenever an RFP is posted, it goes onto a BIDS website. Vendors can register and then get an email that notifies them when a RFP is posted related to categories of interest for the vendor.
7. The process is defined by the procurement rules. Limitations are implemented this way.
8. Communities of contractors that fit in certain categories (single vendors) – they will know that something is coming up. These specific vendors are not tracked. There would be an e-mail record, or publicly posted on website.
9. On BIDS website, how long is the information available for inquiries once the process is complete? Information sits on the BIDS website for 30 days after the award is made. There is a secured site for State staff and an archive that people can access if they work for the state. People from other states or the public cannot access it, but Jim can provide them information if they contact him. There are specific procedures on how to gain information from an old contract.

Known Policy, Legislative, or Other Impacts to the Current Process:

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Policy, Legislation, Initiative	Short Description	Impact to Process
SB 228-07	Monitoring contractor performance	The state controller's office will create a database of contractors who will keep records of how well the contractor performs. The agency (HCPF – Medicaid, CHP, CICP, etc) was excluded from this bill, so they don't have to comply, but they can access the information for performance monitoring.
Executive Order 16	Coordination of outreach	Governor's order requiring all departments to coordinate all IT projects through OIT that are over $10000 or so. The full impact of this order is not known regarding monitoring or outreach. Q&A Thursday and Friday of this week and there is the potential of impact, but none known for now.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Transmittal Database	Transmittals are tracked in an ACCESS database that is internal to the IT division.
BIDS	Communicates procurement documents to prospective and current contractors.
Spreadsheets by vendor name	Contracts and amendments (that contain process changes) – the spreadsheet tracks alterations (new dollars, scope change, etc). This spreadsheet never goes to the contractor.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- What do PHRs and NHRs have to do with any of this? How can clients receive healthcare – this is not talking about providers, rather, it's talking about fiscal agents and other entities.
- QI does a lot of data analysis and then suggests alterations and develops programs to work on what they find.
- CHP does some of this.
- HCPF deals with MMIS related contracts.
- Specific siloed contracting. Not systematically triggered by agency-wide processes. It's not that bad.
- It is coordinated in the sense that it is legislative driven and funnels down from there. Not haphazard.
- May be program specific, but only because looking at the specifics of that program.
- There is an effort toward the competitive nature of the bids, driven by the legislative rules. There are siloed programs, but they are systematically triggered by legislation.
- They have the data to target appropriate populations from claims or other sources (CDC, etc).
- Regarding the contractors who are out there to do the work, there is not great information out there to inform the State of their existence.
- Fiscal Notes process is the "seed" of this process. It is what triggers the process – the entire Department is involved in the fiscal notes process and everyone gets a heads up for the potential new contracts.
- Once the legislation is passed, the Department has to figure out the details of implementation. If there were program sections not impacted, they are not involved.
- Levels 3 – 5 of the Business Capabilities Matrix for Contractor Outreach do not make sense in relation to this process because they are provider focused. The providers do not need to have access to the BIDS system.
- The Department has not achieved Level 3 because they do not have electronic signature abilities. There is some electronic utilization but the process is still highly dependent on paper products.

PROCESS: MANAGE CONTRACTOR COMMUNICATION

Process Description:

The Manage Contractor Communication business process receives requests for information, appointments and assistance from contractor such as inquiries related to changes in Medicaid program policies and

procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed and produced for distribution via the Send Outbound Transaction process.

NOTE: Inquiries from prospective and current contractors are handled by the Manage Contractor Communication process, which provides assistance to and responds to individual contractors (i.e., bidirectional communication). The Perform Contractor Outreach process targets both prospective and current contractor populations for distribution of information regarding programs, policies and other issues.

Current Process Deficiencies, Workarounds, etc.:

1. Inquiries from contractors are around legislation – when can we meet to start talking about the project plan for pending legislation. A lot of inquiries are in response to statements made by the State – requests for clarification, more information, etc. These can be done through phone, e-mail, and meetings but are not generally tracked. They are only tracked when resulting in CSR, Transmittal, or contract amendment.
2. Clarification can be informal, but if it is a systems change, it will be formally documented in a change request document. IPS (Medicaid card vendor) does not have a similar formal method of communication. Neither does IDS. CDS has fairly detailed DDI documentation, and is working to make the requirements documents more detailed and formalized.
3. The documents are stored in versions on the State share. There is a CSR drive that is HCS (not the same as state share, but still a shared drive). CSR is related to the MMIS, all others are CRs besides PCM (Program change management – for web portal). There have not been any IPS change requests to date, so we do not know what they would be called.
4. Trackwise is the MMIS change request form system – it is being replaced by EPM. Another change management system that doesn't do the configuration management – it just keeps track of the projects and assignments.
5. In 2004 and 2005 there were requests from different prospective vendors and states concerning where they were in the procurement process. These questions come somewhat frequently.
6. Either John or Diane Z will respond to these requests according to the information that they can disclose. They are fairly strict on the language, depending on where they are in the process. More information is shared with states than vendors.
7. When it comes to new changes or programs and the Department needs a bid immediately, they can e-mail the current vendor asking for estimates of hours and requesting a bid (high level) to return to the legislature with some level of accuracy and determine if legislation is feasible and whether it will pass (part of Fiscal Notes process). This is sometimes done while the bid is still in the proposal state, and the State does not have the knowledge available in house, they have to ask hypothetical ("in theory") questions. The Fiscal Note process is highly structured. The Budget Division defines and manages this process. HCPF supports their initiatives, but Budget has to compile information and submit the bid. HCPF has to comply with budgetary requirements concerning confidentiality, reporting types, etc.
8. In Fiscal Notes process only existing contractors are pinged (e.g., Colorado Cares – they knew that they might have to issue new cards). They have a relationship with a card vendor already, so they asked them for a potential bid and then may amend their contract to include the new card in their scope of work.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
NA		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Change Management Tracking System	Not a full configuration management system. Tracks CSRs including status and other information regarding a change request to the MMIS.
Inquiries or spreadsheets?	No. MMIS Contract Manager is the only ones who use the transmittals database. Other contract managers may have something like State share, but the guess is not because they want access to the State share used by the Department and ACS.
State share	Shared network drive between IT and the Fiscal Agent – keep claims research, manuals, reference materials, etc. to protect PHI (not in emails).

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Prospective Contractors do not have QA processes.
- Not systematically triggered by agency-wide processes. BIDS is the website. They submit via email and the response is through the website.
- Contractor communication processes are centralized for economy. There is centralized communication regarding the transmittals – recorded, filed, and publicized.
- Specific contract managers have communication funneling through them – measuring efficacy.
- NPS – national postal system – zip + 4, etc.
- Transmittals are paper based because of the lack of capability for electronic signatures.
- Other managers may have other systems. There are strict sign-offs for all change requests. This is standardized. There are levels of acceptance for test results, etc. and we are not sure if agency-wide.
- There is a certain amount of control over these things. Contract managers should realize when things are more formal and document things.
- Other contract managers may be more manual. IT really doesn't know because of the decentralized nature of their systems. They would be going through the program aspect of this process. The rest of the Department doesn't use APDs for funding requests, only IT in relation to the MMIS. The programs use waivers and State Plan Amendments to communicate changes in programs. They all know that IT does APDs, so they may not know that they are supposed to be moving toward this architecture at all.
- According to state Medicaid manual, APDs are for systems-related activities. They don't have to worry about it; however, Level 2 may not reflect the entire Department.

***Changed Business Capability Level to Level 1– based on State Self-Assessment Guidelines released by CMS after the meeting was held indicating "Must meet all criteria of the level". Level 2 may not reflect the entire Department**

PROCESS: SUPPORT CONTRACTOR GRIEVANCE AND APPEAL

Process Description:

The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor

Communications process via the Receive Inbound Transaction process. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearings are documented and relevant documents are distributed to the contractor information file. The contractor is formally notified of the decision via the Send Outbound Transaction process.

This process supports the Program Quality Management business area by providing data about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.

NOTE: States may define "grievance" and "appeal" differently, perhaps because of state laws.
*This process supports grievances and appeals for both prospective and current contractors. A non-enrolled contractor can file a grievance or appeal for example when an application is denied.

Current Process Deficiencies, Workarounds, etc.:

1. There are relatively few grievances or appeals from contractors.
2. During procurement, there are "protests" from people who don't win. Usually only about 2 a year. The initial step of the process is through Jim. If contractors are not satisfied, they can appeal to State Services Director. If they are still not satisfied, they proceed to district court.
3. Keep a paper file for each protest – time stamped in. No formal log because of the lack of numbers
4. Grievances are only accepted on paper. These are kept forever and used as a reference for future responses.
5. As grievances are escalated, records are kept at each level. These are tracked by Jim – he gets copy of appeal, the state director's response, and the court reports.
6. Re: contract disputes – RFP – technically there is a provision in procurement rules where Jim can rule on a dispute. If a minor dispute. If something requiring an escalation, there is provision for notification and resolution of disputes. If close to default, there is a letter sent with deadline to cure the problem.
7. In contract provision, day to day disputes are not spelled out in the contract. These are handled by the contract manager of a given contract. These can escalate to higher levels.
8. There are no hearings for grievances. At the appeal level, the State Purchasing Director could call for a hearing, but otherwise there are no hearings.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
State procurement changed Terms and Conditions for most of the contracts last year		Department can modify Ts and Cs as they need to. Reviewed by the attorney general – the State Controller's office put out a template/boilerplate stuff that is reviewed by the A.G. would send to them for review. Jim escalates this as he sees fit. There are not other additional changes that would affect the boilerplate.
SB 228-07	Database of Contractor performance being collected	Not related to contract dispute exactly, but they will have the

		ability to look at the database and appeal or protest the information in the database, but since HCPF is exclude, the appeal would go to the state controller's office. Their contracts would not necessarily be in the database anyway. Is there potential down the road that HCPF would be included? Unsure why excluded initially. There is an argument behind this occurrence, but they don't know what.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Paper based, but only 2 grievances or appeals annually, so this is not a huge issue.
- Because there are so few instances the process is paper-based, but still efficient.
- Legal based issues – people have to go to court.
- Required by law to have protests and responses on paper.
- Procurement is handled for whole agency by Jim. Contracts all come through him and the protests and grievances are handled by him also.
- Communications are consistent.
- Contractors have access to the rules. They know before filing protests, grievances or appeals what they will be held to from a rule standpoint.
- Process does not take longer because it is paper-based. Procurement rules are based on the model procurement code around the country.

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COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Operations Management

Assessment Session ID:	OM01
Session Date/Time/Location:	July 26, 2007 2:30 – 4:30pm PK Offices
Date Updated:	August 3, 2007

Participants	Role
Carol Reinboldt	Operations Manager
Joan Welch	Business Analyst
Nathan Culkin	Claims Fee for Service Supervisor

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Carol Reinboldt	August 3, 2007 (default)
Joan Welch	August 3, 2007 (default)
Nathan Culkin	August 3, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Authorize Treatment Plan
Authorize Service
Authorize Referral

PROCESS: AUTHORIZE TREATMENT PLAN

Process Description:

The Authorize Treatment Plan business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the client's needs, decides on a course of treatment, and completes the Treatment Plan.

- A Treatment Plan pre-authorizes the named providers and services.
- The individual providers are pre-approved for the service and do not have to submit their own Service Request. It typically covers many services and spans a length of time.
    - A Service Request is more limited and focuses on a specific visits, services, or products.
- The pre-approved treatment plan is a care management function and begins with receiving an authorize treatment plan request data set from either an EDI, Paper/Fax, or phone Inbound Transaction Process, evaluating based on urgency and type of service/taxonomy (speech, physical therapy, home health), validating key data, and ensuring that requested plan of treatment is appropriate and medically necessary.
- After reviewing, the department approves, modifies, pends or denies the request and sends.
    - The appropriate response data set for the outbound transaction or paper/fax notifications or correspondence from the Manage Provider Communication process or sending a 277 Request for Additional Information to the provider.
- A post-approved treatment plan is an audit function that reviews pended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.

Current Process Deficiencies, Workarounds, etc.:

1. The MMIS does not support the submission of a treatment plan that Prior Authorizes all services as outlined in the treatment plan.
2. Single entry point agencies prepare treatment plans. Single entry point: about 25 across the state. Some are counties and some are other entities. TLTC or HCBS. Other entities are not department offices, but other extraneous groups that the department contracts with and pays for case management.
3. LTC needed one case manager to direct all services (home health, waiver qualification, nursing care coordination, etc.) The SEP coordinates the home services that they are going to receive based on the home health services that they qualify for.
4. Do people enter treatment plan? If in waiver, there is a waiver PAR, or a home health PAR. As a case manager, there is a treatment plan behind the scenes. But the treatment plan does not get submitted to the MMIS – not a grouped PAR.
5. Must be authorized by individual services or length of stay.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Consumer Directed Care	At the backend of getting the services.	Part of the treatment plan as to whether the client can manage the care givers or if they have to get a family member to manage care givers.
Waiver Services (DDD)	Developmentally Disabled Waivers (DHS waivers)	Plans may be in BUS but not easily seen or used. Still based per client per service. BUS is not electronically linked to ACS. Case managers can see the BUS. Comes over to MMIS on a one to one PAR service. Either paper or electronically. Treatment plan is required for programs for determining what services are prior authorized, but not sure that they are entered into BUS.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- MMIS does not yet support the entry of treatment plans.
- A unique PAR is required for each service. They cannot be grouped (covering home health, waiver, etc).

PROCESS: AUTHORIZE SERVICE

Process Description:

The Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, surgeries, tests, drugs, durable medical equipment, and institutional days of stay. It is primarily used in a fee-for-service setting.

- The pre-approved is a care management function and begins with receiving a referral request data set from an EDI, Paper/Fax, phone, or 278 Health Care Services Review Inbound Transaction Process.
- Requests are evaluated based on urgency and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state), validating key data, and ensuring that requested referral is appropriate and medically necessary.
- After review, a referral is approved, modified, denied or pended for additional information.
- The appropriate response data set for the outbound 278 Response Transaction, 277 Request for additional information or paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through Manage Provider Communication.
- A post-approved referral is an editing/auditing function that requires review of referral information after the referral has been made.
    - A review may consist of: verifying referral documentation to ensure a referral for services was appropriate and medically necessary; validating provider type and specialty information to ensure a referral is in line with agency policies and procedures.
- Post-approved validation typically occurs in the Edit Claims/Encounter or Audit Claims/Encounter processes.

NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, Inpatient, Out-of-State Services, and Emergencies.

Current Process Deficiencies, Workarounds, etc.:

1. Requests are evaluated based on urgency of service.
2. CO doesn't use a 277. Service requests automatically suspend in the system, waiting for review. If incomplete or needing further information, a Service Request is pended for a few days and a letter is sent out requesting the desired information. This process is manual in that someone reviews it. They can add free-form text to ask for additional information. The Service Request pends for a certain amount of time. If the response is received, the Service Request is processed according to the information contained in the response. PAR is complicated because there are different contract agencies that manage different contract types. ACS does some while CFMC (CO foundation for medical care) does more specialized DME, some medical procedures, occupational and physical therapy, home health, and out of state hospital admissions. DDM does nursing facilities, long term home health care, and hospital back-up programs. Then, there are single entry points that process HCBS programs and waiver programs – these are more case manager types.
3. DHS has some other waiver programs through the Community Centered boards that do the PAs for those programs.

4. Programs are decentralized. The other programs have similar requirements as far as processing time-frames, etc.
5. With ACS, they can submit things through the Web Portal and with other companies. They can only submit via fax or mail and then they perform data entry. TN is doing electronic for some, but not for 278 yet. The Department is working with CFMC to implement the unsolicited 278 (notification and acknowledgement originally rather than the current name – this is HIPAA version 4010 rather than 5010. Working with 4010 for now. Have not adopted the 5010.) Unsolicited is not mandated for anyone to use at this point.
6. Do they process post-approval referrals? Not that they publish or talk about. Inpatient hospitals would be who do the most of this because they do a review of post-pay – but this is more of a medical necessity review. CFMC – retrospective review/post-payment review. This is not done after referral was made.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Unsolicited 278	CFMC	Hoping that if the unsolicited 278 passes/goes well, they will proceed with CFMC in Phase one and then if successful, this will go to DDM group and then on to DHS community center boards (CCBs).

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
CFMC is in the process of implementing a fax server	Providers will be able to fax paper PAR forms to them and automatically enter the information into the system. Then, they will bring information from their system and go to Fiscal Agent for data entry.
Each agency has own system	Does MMIS interface with these? All through paper or key through fiscal agent.
DDM is using 320 bite flat file as is DHS	This is not exactly HIPAA compliant – these are internal business partners and are Plans of Care such that they don't have to pass data in a HIPAA compliant format.
CCMS	External system that sends data to MMIS – what generates the community center boards (CCBs).
DDM	Paradox database provided by the Department.
Internal spreadsheets and similar systems	Paper PARs for private duty nursing for home health. Types of services differ also. PAs differ. Most electronic efforts do not allow revisions. Revisions are manual.
BUS (Benefits Utilization System)	This is where the long term care assessment is performed: every client in a waiver or nursing facility must be assessed to get care. Single entry point

	agencies use this to get information. ULTC 100.2 – long term care assessment paper piece that is automated in the BUS. This is related to authorizing service. When they apply for Medicaid or LTC benefits, they have to have this form. PASSR – also in this (mental health assessment) for Medicaid or non-Medicaid. This is not used to pay claims or used in the MMIS – it's primarily a tracking system. Required before PA process. DDM (Dual Diagnosis Management) manages this. This is about being in a nursing facility that also serves Medicaid and Medicare clients.
320 Transaction	Reverse interfaces from MMIS that go back to submitter. NSF (National Standard Format) 320. These were flat files before HIPAA, but they are still flat files. Once 278 is automated, this will be eliminated.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Many forms are paper-based.
- Manually validated and transferred from paper to MMIS.
- Reviewer manually contacts the submitter/provider.
- Manually validated against state specific rules.
- Mix of paper, phone, fax, or EDI.
- Requests are received through internet Web Portals. Providers can submit service requests electronically.
- Authorize service processes do not generate electronic requests around 277.
- Unstructured paper forms are used in manual review process, such that inconsistent interpretation and application of PA rules persist.

PROCESS: AUTHORIZE REFERRAL

Process Description:
The Authorize Referral business process is used when referrals between providers must be approved for payment. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment.

- Referral authorization usually occurs in certain provider network and managed care settings.
- Authorize referrals closely follows the details of Authorize Service and may not require a separate business process definition.

Current Process Deficiencies, Workarounds, etc.:

1. Primary care/managed care program clients only have to ensure that the PCP did refer the client to the service that was received. As long as their PCP referred them and it's a Medicaid benefit, services are paid for.
2. This is a primarily electronic process. There is not a difference. If there is a PA service, it goes through the same procedures as the authorized service.
3. The authorization itself for some PAR types, they ensure that the billing provider on the claim is the same as the one they authorized the services for.
4. Check managed care program provider to ensure the provider is on the claim and that they are then monitoring the services that are provided.
5. PCP edit does not interact with the authorization edit. This comes into play when they review the PAR looking for a doctor's signature. PAR does not require the PCP on it to be considered for review. PCP is necessary for the claim payment. Therefore, there is some interrelationship between the two.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Medical Home		Will end up decreasing the requirement – it will be an indicator on the provider file. The clients will know that those providers will be functioning as a medical home. It's not like a PCP, but not that different either. At this point, there will not be editing with it. Purpose: part of Colorado Promise. Doesn't edit or audit against it. It is not yet used.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Colorado does not do this process the way it is defined. It seems to duplicate the Authorize Service.
- Review of Authorization requests is manual.
- Referrals are not authorized. Services are.

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Operations Management

Assessment Session ID:	OM02
Session Date/Time/Location:	August 1, 2007 2:00 – 4:00pm PK Offices
Date Updated:	August 15, 2007

Participants:	Role:
Carol Reinboldt	Operations Manager
Timothy Maloney	Operations Quality Control Analyst
Steve Nelson	
Joan Welch	Business Analyst
Nathan Culkin	Claims Fee for Service Supervisor
Peggy Beverly	
Diane Dunn	

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Carol Reinboldt	August 10, 2007 (default)
Timothy Maloney	August 14, 2007
Steve Nelson	August 10, 2007 (default)
Joan Welch	August 10, 2007 (default)
Nathan Culkin	August 10, 2007 (default)
Peggy Beverly	August 10, 2007 (default)
Diane Dunn	August 10, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Edit Claim/ Encounter
Audit Claim/ Encounter
Price Claim/ Value Encounter
Apply Claim Attachment
Apply Mass Adjustment

PROCESS: EDIT CLAIM / ENCOUNTER

Process Description:

The Edit Claim/Encounter E2E business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and

- Determines its submission status.
- Validates edits, service coverage, TPL, and coding.
- Populates the data set with pricing information.
- Sends validated data sets to Audit Claim/Encounter process.
  - Data sets that fail audit are sent to the Prepare Remittance Advice/ Encounter Report process.

All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data. See Constraints.

NOTE: This E2E is part of a suite of processes that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter.

NOTE: The Edit Claim/Encounter process does not apply to:

- Point of Sale, which requires that Edit, Audit, and other processes be integrated, or
- Direct Data Entry, On-line adjudication, or Web-enabled submissions that require field-by-field accept/reject and pre-populate fields with valid data.

Current Process Deficiencies, Workarounds, etc.:

1. Claims/encounters go through most of the steps within the Edit/Claim encounter process with some variance.
2. The dispositions of the edits can be set for claims and set by claim type, or by encounters. The edits are set up based on different business rules. Encounters are not treated the same as claims.
3. If a claim fails the edit process, the claim would then be returned or put on the remittance advice. The claims are either accepted or rejected. Audits only look at the paid claims or those awaiting payment. If the claims are rejected or suspended, it would not proceed through to the audit process. Suspended claims do not go on.
4. The provider claim report would show if a claim is denied. Rejected claims do not show on the report. They show up on the EDI report – they may be missing their billing ID or something important that prevents EDI from processing the claim.
5. No manual processing for electronically submitted claims unless the claim requires manual pricing.
6. Claims automatically suspend based on certain criteria and have to be worked by the Fiscal Agent.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Webportal	If they reject, the claims don't stay In MMIS longer than 10 days. The provider has to fix whatever is wrong with the claim and resubmit.
Pharmacy claims	Adjudicated in the pharmacy system and sent to MMIS. This is external. They go to MMIS to be \ paid and for claims history.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Agency receives paper claims conforming to state standards. Data elements trigger edit/audit.

- Most providers submit claims via Web Portal, etc. It is electronic submission primarily. (L2)
- Companion guides. (L2)
- Transmitters support business processes.
- Encounter data – problem in Level 2. BHOs are still doing things on a flat file in parallel to the electronic submission. In transition from one to two now (for HIPAA)
- The ability to receive things is there, but the compliance is not yet there. Not used for payment, but you still have to price it. Keeping the data segregated to say which data was submitted and what should be returned. This is wanted to use to help set rate data. The system is ahead of the process in that way.
- Waiver process – CO can accept their claims. There are programs that DHS does that are outside of the MMIS and there are some programs that are outside of the MMIS. There are waiver programs external to the system. DHS doesn't do claims processing the same as HCPF does. DHS certifies the providers, and are loaded into the MMIS, but DHS is not necessarily involved.
- What does "sister agencies" mean? Not all of the programs are done through the MMIS. They administer some and reimburse them and control them aside from the state. There are some with business arrangements to do the claims processing.
- There is not anywhere that they do the big picture.
- L2 timeliness of process – waiver claims submitted to siloed payment systems. This sounds like the DHS process and it's a payment system for some of those.
- From a Medicaid program standpoint, they are centralized and all goes in there waiver or not.
- Provider claim report does the 270s via the webportal.
- Request for corrections is done through an edit setting on a claim.

PROCESS: AUDIT CLAIM / ENCOUNTER

Process Description:

The Audit Claim/Encounter E2E business process receives a validated original or adjustment claim data set from the Edit Claim/Encounter process and Checks Payment History Repository for duplicate processed claims/encounters and life time limits.

- Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity.
- Suspends data sets that fail audits for internal review, corrections, or additional information.
- Sends successfully audited data sets to the Price Claim/Value Encounter process

All claim/encounter types must go through most of the steps within the Audit Claim/Encounter process with some variance of business rules and data. See Constraints.

NOTE: This E2E is part of a suite of processes that includes: Edit Claim/Encounter, Audit Claim/Encounter, Price Claim/Value Encounter, Apply Claim Attachment, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter.

Current Process Deficiencies, Workarounds, etc.:

1. Receives an original or adjusted claim and checks for duplicate or lifetime limits for the service
2. Verifies approval and appropriateness. Suspends dataset that fails audits for internal review or corrections or additional information. Goal is to price it. Audits against history and against service limits. These are done in a different order. They price before auditing and again later. The pricing is in two areas because it's how the system is set up. This is called pre- and post- calculated rate changing. Rate could change after auditing – could do final cut backs or add-ons.

3. Add-ons – PETI (Post Eligibility Treatment of Income) – sees that there is PETI information on the claim and they add on to the price. Most of the time this pays less having to do with co-payments and other cutbacks done later.
4. Pre-pricing – is pricing based on rate schedules. It only considers submitted charges.
5. Other than pre-pricing, they do all the same as above. Look at case history, verify authorizations, etc (business rules)
6. When audit is complete, they do the post-pricing piece. Then, all claim types go through the audit.
7. Encounters do not go through the audit. They go through everything, but the edits are turned off. No money goes out, so it's not that big a deal. This is in terms of service limitations, etc. Even services that are once in a life time go through this. It's a report and not a claim – it collects data.
8. Audits can be set to ignore.
9. Note part (above): claim attachments are not accepted electronically. Electronic claim attachments are not done.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 2

Rationale:

- This should be the same as the Edit Claim encounter above.
- Processes meet HIPAA standards (98% electronic claim process).

PROCESS: PRICE CLAIM / VALUE ENCOUNTER

Process Description:
The Price Claim/Value Encounter business process begins with receiving a claim/encounter data set from the Audit Claim/Encounter Process, applying pricing algorithms, calculates managed care and PCCM premiums, decrements service review authorizations, calculates and applies member contributions, and provider advances, deducts liens and recoupments. This process is also responsible for ensuring that all adjudication events are documented in the Payment History Repository from the Manage Payment History process and are accessible to all Business Areas. All Claim Types must go through most of the processes and sub-processes but with different logic.

NOTE: An adjustment to a claim is an exception use case to this process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the Payment History Repository.

Current Process Deficiencies, Workarounds, etc.:

1. Receive from audit process.
2. Apply pricing algorithms.
3. PCP – part of managed care system (Managed care premiums).
4. Reviews authorizations.
5. Calculates and applies member contributions.
6. Provider Advancements – done manually. Once in, tracked systematically, but advanced payments are manual.
7. Manually deducts liens and recoupments– financial transactions to recoup monies. There is a manual work-around if needed. Most recoupments are automatic and performed within the MMIS. Liens are done manually, outside of the MMIS. They are taken from the vendors (provider's) check (in the state accounting system- COFRS).
8. Adjudication events are documented in payment history and are accessible to business areas. Recoupments show up on provider claim reports. Payment history is accessible.
9. Claim types go through processes or subprocesses with different logic.
10. Claim adjustments are exceptions, and follow the same process with a link to the previously submitted and processed claim.
11. There are no adjustments to encounters. The value/price encounter is the same. The functionality is there, though: if you can void an encounter, you can adjust it. Encounter claims are accepted or rejected, but not suspended. Adjustments would not go through the financial cycle because it is an encounter. There is some indication that it is an encounter rather than a claim. This is at the top of the 837 where there is an "R" for reporting rather than the "C" for claim.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Colorado Promise		Pricing, More HMOs, Increases encounters

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Automatic pricing.
- Values assigned based on the same reference data.
- Manual pricing is NOT done in encounters, but there is some in claims.
- Staff adjustments – atypical provider services are NOT manually priced. Provider advances are manual. Member contributions are all taken from the claim as are recoupments. Deduction of liens is handled outside of the MMIS. Waiver services are handled normally through the same process as everything else

- Most manual pricing is done on claim type I (Medical Supply) – for different equipment etc. based on invoices. That data is loaded in the system in a different way.
- Not many manual priced systems.
- Single claim adjustments are automated using the webportal. Adjustments are submitted through 837.
- Pricing formulas are agency specific. DHS prices are done through a PAR – automated. There are not manually priced waivers for atypical providers.
- "Sister Agencies" problem – coordinating with them to present a "one stop shop" claim adjudication and pricing process. Taken Department of Public Health and Environment processes into HCPF after HIPAA implementation. We put the pricing into MMIS and DHS has to follow MMIS to get claims paid. This includes mainly waiver, alcohol and drug abuse, and wayward children.
- L3 – no MITA standards exist yet.

PROCESS: APPLY CLAIM ATTACHMENT

Process Description:

This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) from the Edit Claim/Encounter or Audit Claim/Encounter process or has been sent by the provider (unsolicited) from the Receive Inbound Transaction process.

- The claim attachment is linked with a trace number to the associated claim.
- The claim attachment is stapled to a claim.
    - Or, pending the attachment data set for a predetermined time period set by edit and/or audit process rules, validating application level edits, determining if the data set provides the additional information necessary to adjudicate the claim.
        - If yes, moving the attachment with claim to the next adjudication process.
        - If no, move to payment processing as a denied claim or trigger a request for additional information, and purging an attachment data set after a predetermined time period set by edit or audit process rules if no claim is found.

NOTE: If no claim is found, the attachment data set is pended for a predetermined time period in accordance with state specific business rules. After this time period, the attachment data set is purged.

Current Process Deficiencies, Workarounds, etc.:

1. Receives an attachment that has either been requested by payer or has been sent by provider and linked with a trace number to associated claim, etc., moving to next adjudication process or to a denied claim or request for additional information.
2. They deny it and ask for required information. The only time that something is pended is when it's a PA.
3. The provider cannot send an attachment in separate from the claim. If they require an attachment, it has to come in on paper with the paper claim. They cannot submit a claim electronically and send a required attachment on paper to be scanned and linked in the MMIS. Sometimes the attachment can be waived, but generally, they have to submit on paper with attachment. If submitting for equipment services with a UB modifier, they will accept it electronically
4. TPO prior and Medicaid prior – there is not a set in stone requirement for an attachment if they use the right modifier. If the provider does not, the claim is denied and sent back for more information.
5. More efficient and cost-effective to do electronic claims.
6. What drives the decision of whether a modifier can be used on a claim with or without an atatchment? The forms (CO-1500 or UB92).

7. Still manual. Do have electronic override with modifier use.
8. No electronic manner of generating letters to request more information/attachments.
9. Tried to develop a process to marry the 275 with the 278. This did not work due to excess volume. The mail room is a constant source of complaint.
10. When the attachment comes in it is scanned, but there is no system to enter the attachment into. There would be a huge system alteration if the attachment rule went through. The Medicare system automatically generates information – letter, edits, requests, etc. They have no process that sends out communication and asks for answers back while they pend a claim. They may do it with PAR, the 278, because with those, there is a process of pending and waiting for letters. This is not in the claims subsystem, it's only in PARS. There is not a movement to move this to claims. The current system (requesting a re-submittal) is as fast as sending a letter out requesting specific information.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Electronic claim attachment transaction	275	Attach claims electronically.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
ACS scans into their system (electronic document management system) Docfinity	Paper received requiring processing – interfaces with MMIS. Web based program. Only a few people have access to it at HCPF. It contains the TCNs, reference number, provider IDs, etc. Can look at how information is entered into the MMIS. This is only for paper claims, PAs, provider enrollment information, transmittals from the state (requested changes of ACS).

Current Business Capability:

Maturity Level: Level (currently this process is not supported as MITA defines it because it all comes in on paper, so there is no matching done).

Rationale:

- Don't do attachments separate from the claims.
- And why would you want to do that anyway?
- There are MMISs that pend claims and link by control number.
- Need more provider compliance to move toward this as well. Providers don't always send in the right information after things are pended (repeatedly).
- As the process is not feasible for external reasons, there would be no return on investment for enabling it within the system.

PROCESS: APPLY MASS ADJUSTMENT

Process Description:

The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with HCPCS, CPT, Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes

- Identifying the claims by claim/bill type or HCPCS, CPT, Revenue Code(s), or member ID that were paid incorrectly during a specified date range,
- Applying a predetermined set or sets of parameters that will reverse the paid claims and repay correctly.

This business process often affects multiple providers as well as multiple claims.

NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment involves many claims within a range of dates submitted by multiple providers.

Current Process Deficiencies, Workarounds, etc.:

Any information regarding process deficiencies in meeting business needs and any workarounds used to supplement current automated processes required to meet the business need.

1. Mass adjustments are now done up at ACS with PDCS X2 based off of certain criteria.
2. Retroactive changes are done. They may be changed rates, revenue codes, or program modifications or conversions. They include claims that were paid incorrectly. This affects multiple providers as well as multiple claims. (Member = Client).
3. Mass adjustments of denied claims are another item that CO does in addition to the paid claims. They can find the claims that are denied incorrectly and mass adjusted (there are various parameters that can be searched out). They are not always paid claims.
4. They can mass adjust certain claims with minimal interaction.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
PDCS	Feeds pharmacy data into MMIS.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Primarily electronic.
- Mass Adjustments are identified electronically. They can mass adjust back to specific dates.

- There are audit trails. They produce adjustment analysis reports so that you can see the differentiation. Sometimes the post-adjudication amounts are inaccurate. The actual history maintains the TCNs of the adjustments that come after it (all will be noted).
- There are links that mark the Mass Adjustment of the most recent and only that claim would be active.

Public Knowledge LLC
Management Consultants

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Operations Management

Assessment Session ID:	OM04
Session Date/Time/Location:	August 2, 2007 2:30 – 4:30pm PK Offices
Date Updated:	August 10, 2007

Participants:	Role:
Carol Reinboldt	Operations Manager
Steve Nelson	
Joan Welch	Business Analyst
Nathan Culkin	Claims Fee for Service Supervisor
Diane Dunn	Claims Section Manager
Terri Davis	

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Carol Reinboldt	August 10, 2007 (default)
Steve Nelson	August 10, 2007 (default)
Joan Welch	August 10, 2007 (default)
Nathan Culkin	August 10, 2007 (default)
Diane Dunn	August 10, 2007 (default)
Terri Davis	August 10, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Prepare Remittance Advice/ Encounter Report
Prepare COB
Prepare EOB
Prepare HCBS Payment
Prepare Provider EFT/ Check
Prepare Premium EFT/ Check

PROCESS: PREPARE REMITTANCE ADVICE / ENCOUNTER REPORT

Process Description:

The Prepare Remittance Advice/Encounter Report business process describes the process of preparing remittance advice/encounter EDI transactions that will be used by providers to reconcile their accounts receivable.

- This process begins with receipt of data sets resulting from the pricing, audit and edit processes.
- Required manipulations are performed according to business rules.
- Results are formatted into the required output data set.
- Output data set is sent to the Send Outbound Transaction process.

The resulting data set is also sent to Manage Payment History for loading.

NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.

Current Process Deficiencies, Workarounds, etc.:

1. All of the above is true. Encounter report is different than all encounter reports. Intent was for providers to use it for their work. Plans are still in testing. The plans have not determined how to transmit a clean file through to ACS (this should be done by end of August).
2. RA – 2 pieces. 1) 835 HIPAA transaction (RA) 2) Provider Claim Report - additional information which a provider can choose to use (text file loaded off of the file report service)
3. The encounter report is called the data quality report – similar to provider claim report, but not exactly the same. It provides additional information to the 835. It is intended to go as a file.
4. There is extra information for the providers and encounters do not go in an 835.
5. The 835 is a payment device. Encounters are not sent through the financial process; they cannot end up on the 835. The data quality is on the data quality report
6. Discussion with providers about whether 835s are compliant. Adjustment reason codes are vague and do not provide sufficient information – therefore the provider claim report is necessary. They are more Medicare specific than Medicaid.
7. If it does pay, they get balancing information on the 835. The claim report is help for reconciliation for the smaller ones.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
The next MMIS		Getting providers trained and acclimated.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Medicaid agency provides paper RAs to providers who are not electronic billers.
- The agency complies with HIPAA to supply an electronic RA that meets state agency implementation guide.
- Offered on paper by exception for new providers. Moving to total electronic.
- 2002 – major budget cuts having to do with what to do with fiscal agent contract – went to as much electronic as possible.
- Provider claim report – careful not to move too many people to it because of the outcry. Had to wait for the web portal, etc. It has grown over the years, but it was originally a budget cut effort.
- HCPCS bulletin is different procedure code changes that now go on CD every January (provider communication)

PROCESS: PREPARE COB

Process Description:

The Prepare COB business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries.

- The Prepare COB business process begins with the completion of the Price Claim/Value Encounter process.
- Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the original claim and/or eligibility files.
- This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set, validating that the outbound EDI transaction is in the correct format and forwarding to the Send Outbound Transaction.

Current Process Deficiencies, Workarounds, etc.:

1. Scott's team does do post-payment coordination of billings on paper.
2. ICVR – (Insurance Carrier Verification Request) ensure that third party benefit information is correct.
3. HMS – recovery on Medicare things that we paid that Medicare should have paid and other third party insurances, where they know about third party insurances and we don't. They get a file from other insurance carriers, and look for the client and when they match it they find it and make sure that they paid.
4. HWT – unbundling stuff
5. Do cost-avoidance – this is denied, then why would you forward it on? Forward the claim to the other insurance so that the provider only sends it one. HIPAA – put all carriers on the claim at the same time. So if there was an 837 with a 1G insurance, they would coordinate over to their insurance.
6. Claims are flagged and moved to a file (see above). This includes retrieving claims data necessary to generate the outbound transaction including retrieval of any data stored, etc (see above)
7. 3 sets of data that go to contractors – used for the purpose of getting recoveries. 2 files go to HMS, 1) for estate recover (over age 55 claims) 2) all claims used for Medicare and Third party insurance recovers. HWT gets all claims including paid and denied claims with denial codes, providers and clients.
8. Most of this work is outsourced. They load claims into system electronically. Notifying the providers is done on paper.
9. Cost avoided claims – are denied and sent back to the provider and told them to bill someone else. That's where the provider claim report comes in. They tell who the carrier is and what their address is and possibly the policy holder number and group number.
10. MSQs and wheel chairs are a little different. MSQs (Medical Service Questionnaire) – prompted off of an accident notice. There is an accident occurrence code. They send a form to client indicating the date of service of the potential accident. It asks are you planning to sue and are you working with a lawyer. If planning to sue, the state will take their cut from the settlement. (tort and casualty recoveries). Coordinating with other insurance companies, or an auto insurance, or other kinds of insurances to ensure that the state gets the fair cut on it. Up to that point, they still pay the provider, hoping to recover through the settlement. If there is an auto insurance, they are expected to be used primarily. MSQs go out on paper and return on paper – all very manual.
11. Wheelchairs – the policy may be changing. Historically, because of the differences in Medicare and Medicaid policies. Medicaid would pay for the wheelchair if the client was dually eligible, because

Medicare does not cover "convenience items" like wheel chairs. Rather than have the client stuck, they get Medicaid to cover it first. Due to an audit, they are thinking about changing the policy.

12. The state will pay for complicated wheel chairs. Medicare only pays for stuff within the home. There are different procedure codes for each. They have discussed with policy and the wheelchair advisory committee on how to pay the difference and not bill the lower of the two.
13. Part D – changed how things are working. Infusions, cancer drugs – considered part B benefit, but they are calling them supplies. Where the drug is delivered dictates the type of benefit. This changes the COB process. All electronic.
14. HMS sends a file back that says that they recovered this money on these claims. They mark the claims on different types of recoveries. This information is brought over in a file load. The biggest one is marking pharmacy claims because there are not corresponding reason codes in X2 from MMIS. Pharmacy codes have been financial transactions before.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Wheelchair policy	Trying to figure out who pays for wheelchairs.	

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
COB staff maintains databases	
HWT and HMS work	Maintained outside of the system
HMS file that comes back with the claims to be marked as adjusted.	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Medicaid agency uses the resource intensive model for submit denied claims to other payers. However, the cost avoided claims are not forwarded to primary payers.
- L1 – there is a mix of paper and EDI claims with non-standard data.
- Post-payment information is sent on paper, but they think that there is a standard claim form (paper). Post-payment recovery is primarily manual and mostly paper-based.
- Letters go to the carriers. We think that HMS generates claim letters and forms.

PROCESS: PREPARE EOB

Process Description:

The Prepare EOB business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the explanation of benefits (EOBs), and processing returned EOBs to determine if the services claimed by a provider were received by the client. The EOBs or letters must be provided to the clients within 45 days of payment of claims.

- Sample Data is identified using random sampling methodology, retrieving the sample data set.
- Explanations of Benefits (EOBs) and/or notification letters are prepared.
- The data is formatted into the required data set, which is then sent to the Send Outbound Transaction process for generation.
    - The resulting data set is also sent to Manage Applicant and Member Communication.

NOTE: This process does not include the handling of returned data nor does it include sending the EOB Sample Data Set.

Current Process Deficiencies, Workarounds, etc.:

1. EOB = EOMB in CO – this is the client piece. This is just preparing to send those out. It's an electronic process.
2. Processing the return was just changed.
3. They are looking better – more understandable for the client.
4. New piece in the RFP around the receipt back of the EOMBs. Instead of coming back to the department, the letters are shipped to ACS to process and track on a spreadsheet. Only the ones who claim not to have gotten the service are sent back to the department. ACS does the follow-up. A report is done monthly saying how many sent out, returned, approved, denied, etc. The system picks clients – a fixed number of clients are picked using a random sampling algorithm.
5. The EOMB is sent to managed applicant and member communication processes.
6. EOMB go out on paper. The file work is electronic.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Audit finding that more should be done (State auditor's office)	That section has to do a budget request and get the postage.	More sent out. A broader sample will be gathered. The budget has to be received before they change the system.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Spreadsheet	Tracking – manually. Accumulate letters throughout the month. The last of the month, they enter the letters and send out a report.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- The sampling process does not target selected populations.
- Sensitive services can be suppressed. There are diagnosis codes and classes of drugs.

- They do this monthly (not quarterly).
- All performed in English.

PROCESS: PREPARE HCBS PAYMENT

Process Description:
Many home and community based services are not part of the traditional Medicaid benefit package. Services tend to be client specific and often are arranged through a plan of care. Services for Home & Community Based waivers are often rendered by a-typical providers and may or may not be authorized or adjudicated in the same manner as other health care providers.

The Prepare Home and Community-Based Services Payment business process describes the preparation of the payment report data set. The payment report data sets will be sent on paper or electronically to providers and used to reconcile their accounts receivable.

- This process begins with receipt of data sets resulting from the edit, audit, and pricing processes.
- Required manipulation is performed according to business rules.
- Results are formatted into the required output data set.
- The required data output set is sent to the Send Outbound Transaction process for generation into an outbound transaction.
- The resulting data set is also sent to Manage Payment History process for loading into the Payment History Repository.
- The reimbursement amount is sent to the Manage Provider Information process for loading into the Provider Registry for purposes of accounting and taxes.

NOTE: This process does not include sending the home & community based provider payment data set transaction.

Current Process Deficiencies, Workarounds, etc.:

1. Same process as for all claims except for single entry point agency administrative fees (case management piece is considered an administrative service)
2. All administrative services are paid outside of MMIS. All HCBS medical services are done through the system.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Enroll the providers with the same information.
- Have to do EFT
- Have to do electronic billing.
  Paid with a claim
- Becoming more like one another not less.
- Services are expanding.

PROCESS: PREPARE PROVIDER EFT / CHECK

Process Description:

The Prepare Provider EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:

- Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, HCBS provider claims, and MCO encounters based on inputs such as the priced claim, including any TPL, crossover or member payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and taxes, performance incentives, recoupments, garnishments, and liens per data in the Provider Registry, Agency Accounting and Budget Area rules, including the Manage 1099 process
- Payroll processing, e.g., for HCBS providers, includes withholding payments for payroll, federal and state taxes, as well as union dues
- Disbursement of payment from appropriate funding sources per Agency Accounting and Budget Area rules
- Associating the EFT with a X12 835 electronic remittance advice transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the remittance advice within the banking system may not be HIPAA covered entities]
- Routing the payment per the Provider Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction
- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history
- Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate, e.g., Pharmacy POS

Current Process Deficiencies, Workarounds, etc.:

1. We do not do taxes, performance incentives, garnishments or liens. In calculating the payment – they recommend the payment to COFRS who may adjust for taxes and liens. It all goes in and combines data elements per tax ID number. Therefore, if a provider is doing business with the state in several areas, they will use one tax ID number. This also includes the 1099 process. The state does a preliminary 1099 out of the MMIS.
2. They do not withhold for providers. IF the HCBS in turn pay individual providers, that's up to them. Agencies do all of the tax withholds, etc. (Intermediary service organizations)

3. EFT with 835 – if agency sends through the HCA system – they send through COFRS – and then COFRS sends back a list of EFT and warrant numbers that they then put on the 835. HCA – clearing house is the state's and not the MMIS's. It's a COFRS function and not the MMIS function. So, when Terri sets up stuff with EFT, it's to make sure that the ACH has all of the routing numbers. This is all manually entered by the state controller's office (SCO).
4. ACH is manual initially.
5. POS adjudicates POS and does not pay it because they have to go through the state treasurer's office. No real-time payments are on anything.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Loading providers into COFRS two interfaces:	Paying providers	
Add interface (CSR 2198)	Currently weekly (want daily)	Less cost, fewer errors (updates happening before adds)
Update interface	Currently daily	

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
N/A	

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Conforms to HIPAA.
- Agency encourages electronic billers to adopt EFT payment.

PROCESS: PREPARE PREMIUM EFT / CHECK

Process Description:
The Prepare Premium Capitation EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including

- Calculation of
    - HIPP premium based on members' premium payment data in the Contractor Registry
    - Medicare premium based on dual eligible members' Medicare premium payment data in the Member
    - Registry
    - PCCM management fee based on PCCM contract data re: difference reimbursement arrangements in the Contractor Registry

  - MCO premium payments based on MCO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid MCO and benefit package in the Contractor Registry
  - Stop-loss claims payments for MCOs in the Contractor Registry
- Application of automated or user defined adjustments based on contract, e.g., adjustments or performance incentives
- Disbursement of premium, PCCM fee, or stop loss payment from appropriate funding sources per Agency Accounting and Budget Area rules
- Associate the MCO premium payment EFT with an X12 820 electronic premium payment transactions required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately. [Note that this approach has privacy risks because entities processing the Premium Payment within the banking system may not be HIPAA covered entities]
- Routing the payment per the Contractor Registry payment instructions for electronic fund transfer (EFT) or check generation and mailing, which may include transferring the payment data set to a State Treasurer for actual payment transaction
- Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid premium, fees, and stop loss claims transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history
- Support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real time payments where appropriate

Current Process Deficiencies, Workarounds, etc.:

1. HIBI = HIPP
2. They don't have any PCCMs that get a fee basis (don't do the fourth sub-bullet)
3. There is no national code that will match – there was a local code. Instead of paying it as a small fee for incentive. This worked out for advantage.
4. Capitation – managed care gets an 820.
5. A PCP incentive payment was supposed to appear on an 835, but now we don't pay the incentive.
6. They do not have performance incentives that are done online. They are done through the accounting system. The accountants can get into COFRS and cut a separate check to say this is half of how much you saved us last year – it's a manual check. They are entered in by the tax ID number. These payments show up on the 1099 for these providers.
7. Premiums are paid through COFRS. There is not a primary care management fee. Stop loss payment is not a true stop loss payment.
8. Associate EFT with 820 that has the same rules as the 835 – they go through with the warrant number coming back on it.
9. The payment is made based on the information that they have on the contractor/provider registry.
10. There is an interface between COFRS – there are two major things: 1) every Monday they send the COFRS interface tape over to COFRS that includes all of the recommendations for payments. 2) Then, on Friday afternoon, they get back a listing of the warrant numbers and EFTs (which then get processed as part of the financial cycle). Friday night, they run the financial cycle, COFRS puts it into the financial clearing house, on Tuesday nights, the checks are generated, they get the checks on Wed. morning, and then they get to the providers about the same time that the direct deposit would. Friday afternoon a week later, they get the warrant numbers and EFT numbers. They generate the 820s and 835s on that Sunday. Provider claim reports are posted to the FRS. 820s and 835s are posted on the week after the process starts.
11. Updating files are based on paid and pended premiums (that they try to resolve within the week). Capitations are created on the same day of the month. They run them once a month. If they have lost eligibility between Saturday and the day it runs, they will suspend it. Since they do not process any client files, we don't understand how they lose eligibility in that time. Client file, managed care

assessment, PDCS client files, financials, and managed care (is the order). There is no change in eligibility in this process. The next time that the clients are updated is Monday night, so the clients should either be in "to be paid" or "to be denied" status.

12. They use the same interfaces for the plans as before.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
COFRS (see above and previous process)	

Current Business Capability:

Maturity Level: Level 2

Rationale:

Same as last process.

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Operations Management

Assessment Session ID:	OM06
Session Date/Time/Location:	August 7, 2007 1:00 – 3:00 pm PK Offices
Date Updated:	August 16, 2007

Participants:

Name	Role
Laurel Karabatsos	Benefits Division Director
Jerry Smallwood	Managed Care Manager
Gary Ashby	Manager of Benefits Coordination
Sharon Brydon	Benefits Coordination
Steve Nelson	Claims System Supervisor
Peggy Beverly	
Cynthia Oten	Interface Programmer
Dan Rodriguez	Business Analyst
Mark Gray	Claims System Business Analyst
Diane Dunn	Systems Analyst

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Laurel Karabatsos	August 15, 2007 (default)
Jerry Smallwood	August 15, 2007 (default)
Gary Ashby	August 15, 2007 (default)
Sharon Brydon	August 16, 2007
Steve Nelson	August 15, 2007 (default)
Peggy Beverly	August 15, 2007 (default)
Cynthia Oten	August 15, 2007 (default)
Dan Rodriguez	August 15, 2007 (default)
Mark Gray	August 15, 2007 (default)
Diane Dunn	August 15, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Prepare Health Insurance Premium Payment
Prepare Medicare Premium Payment
Prepare Capitation Premium Payment

PROCESS: PREPARE HEALTH INSURANCE PREMIUM PAYMENT

Process Description:
Medicaid agencies are required to pay the private health insurance premiums for members who may have private health insurance benefits through their employers and because of devastating illness are no longer

employable and become Medicaid eligible. It can also include children who are Medicaid eligible but also have private health insurance provided by a parent(s). In these circumstances, a cost effective determination is made and a premium is prepared and sent to the member's private health insurance company rather than enrolling them into a Medicaid managed health care plan or pay fee for service claims as submitted by providers.

The Process Health Insurance Premium Payments business process begins by receiving eligibility information via referrals from Home and Community Services Offices, schools, community services organizations, or phone calls directly from members; checking for internal eligibility status as well as eligibility with other payers, editing required fields, producing a report, and notifying members. The health insurance premiums are created with a timetable (usually monthly) for scheduled payments. The formatted premium payment data set is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Maintain Member Information for updating.

NOTE: This process does not include sending the health insurance premium payment data set.

Process Description Corrections:

- Medicaid agencies are no longer required to pay private health insurance premiums. It became optional in 1996 or 1997.
- Different states provide different levels of services. In Colorado they pay premiums in addition to cost sharing – deductibles, co-insurance, and co-pays.
- Several of the terms used in the description are not terms used in Colorado.
    - An assumption was made that Home and Community Services Offices equates to Colorado County Offices.
    - "Send Outbound Transaction" is not a term used in Colorado.

Current Process Deficiencies, Workarounds, etc.:

1. Referrals are received from county workers at the time of application and redetermination. Other means of referral are through advocacy agencies and word of mouth.
2. A Health Insurance Buy-In (HIBI) request must have:
    - MS-10 form (health insurance reporting form – used for any client)
    - Heath Insurance Buy-In Request Form (how much is the premium, how is it paid, is it court ordered, etc. – specific to payment of the premiums)
        - If premium covers more than one person, there is a premium price sheet from either employer or heath insurance that gives the break down of the family set-up to determine what portion of the premium will guarantee coverage.
3. Work-Around – Medicaid clients are enrolled as providers.
    a. A cost effective determination is made and a premium is prepared and sent to the member's choice of payee: an individual (e.g., policyholder) or a company (e.g., health insurance carrier, employer or COBRA administrator). A HIBI client cannot be enrolled into a Medicaid managed health care plan because Medicaid would be paying two premiums. Providers are expected to bill Medicaid fee for service after billing the private health insurance. Medicaid will pay the different between the private health insurance payment and the Medicaid allowed amount.
    b. Since HIBI only pays a portion of the premium, the payment rarely goes to the employer or insurance carrier. Instead, it goes to the policy holder r other individual of the client's choice. Payroll deductions are required by employer sponsored insurance – so the work-around must stay in place.

c. The State determines the HIBI amount, enrolls the client or other payee as a special HIBI provider, creates a financial transaction, and pays the client, who then pays or is reimbursed insurance-related costs. These clients are already enrolled in Medicaid. The clients are essentially providing services to themselves.
d. Payment is different than it would be for typical providers. Clients do not submit claims. Instead the State updates the "HIBI" tab on the client resource file. The system automatically creates a financial transaction (gross adjustment) based on the information on the HIBI tab. This is how clients are approved for up-front monthly payments. Clients receive a certain dollar amount is based on the premium amount (on premium sheets). In some cases, the State uses COBRA or individual rates.

4. Most payments are made to clients; however, some payments are made directly to insurance companies. ACS has to have remittance advises (RAs) in order to pay the insurance providers.
    e. Sometimes the paper warrant does not match with the system-generated RA. When this occurs, we hope that the address on the system generated RA and on the paper warrant are the current addresses so that they get to where they need to go – though they may be in separate envelopes. If not, hopefully the check gets forwarded to the current address. If not, it goes to the Controller's office, the check is voided, and has to be manually re-produced.
5. Nonstandard payments require a workaround:
    f. When HIBI clients are first approved, they are retroactively approved in the sense that they get their coverage from the date of application. Clients receive a lump sum from the beginning of the coverage through the month of their payment.
    g. If payments are suspended, they receive payment on a reissue. Clients are supposed to notify the State in a timely manner if they move or there are other changes, such as to their insurance coverage.
    h. If clients are underpaid or overpaid, there are manual processes to correct the payments.
    i. HIBI tab for "Additional Disbursements" does not work. They have to set up a HIBI tab for a different resource (e.g. use the pharmacy tab instead of the major medical tab in order to not disrupt the monthly payment). This function allows them to pay nonstandard payments and then add a description for the services paid for.
6. Financial transactions are documented on paper to process incoming money or when impossible to use HIBI tab to make outgoing payment. For example, if a client is no longer eligible, the MMIS will not let the payment go through. In order to make an outgoing payment, the State has to complete a paper transaction. This is another reason it would be good for "Additional Disbursements" window to work.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Colorado Promise		Keeping people in control of their own insurance. This is already in place. And they will be doing it with CHP+.
HIFA (Health Insurance Flexibility and Accountability)	CHP+ waiver to provide services	In order to get renewal, they had to get a buy-in for the insurance. They just got the 07-08 budget amendment and hope to have it up by March of 08 – this will be up to $100/child based on the employer sponsored insurance (ESI). They will receive ESI

		rather than CHP+ benefits. CHP+ has no stop-loss or wrap-around.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Transmittals are sent to ACS	They say which clients are enrolled as providers. This feeds into COFRS.
CBMS resource file into MMIS	Once a week it comes into MMIS as an update file. This is true for paying co-insurance amounts as well.
Paper payments	Financial transactions done on paper to process incoming money or when impossible to use HIBI tab to make outgoing payment. E.g., If a client dies (they are no longer eligible), the MMIS will not let the payment go. In order to make outgoing payment, there has to be a paper transaction. Another reason it would be good for "Additional Disbursements" window to work.
Resource file sent from CBMS to MMIS	Tuesday afternoons- eligibility information
Carrier file sent from CBMS to MMIS	Tuesday afternoons- eligibility information

Current Business Capability:

Maturity Level: Level 1
Rationale:

- Colorado does not use HIPAA compliant transactions.
- HIPAA compliant 820 transaction (premium payment – how they advise managed care plan electronically) – because State Treasurer's Office is the only one who can pay, the 820 is a remittance advice.
  - If a transaction is generated at all, it would be an 835 transaction that is used to advise payment.
  - COFRS is the only system where payments are made.
  - If they tried to set up a way for clients to receive an 820, they might not be able to read a HIPAA compliant transaction.
- 856 transactions are almost all client payments and hardly any direct insurance provider payments. Over time, they may become more sophisticated, but it's doubtful that they will move toward being HIPAA compliant any time soon.

PROCESS: PREPARE MEDICARE PREMIUM PAYMENT

Process Description:

State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process State Medicaid agencies, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance.

The Prepare Medicare Premium Payments business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History and Manage Member Information for loading.

NOTE: This process does not include sending the Medicare premium payments EDI transaction.

Process Description Corrections:

1. Process begins with the counties where eligibility information is entered into CBMS.
2. CBMS sends eligibility data to the MMIS, where Medicare Buy-In lives.
3. MMIS determines who will be eligible for Medicare premium payments.
4. A State request to either start or stop buy-in for Medicare Part A or B premiums is sent to CMS Baltimore.
5. CMS matches the data sent with other databases – SSA, Railroad Retirement Board, or Civil Service.
6. CMS responds to the State with either a RIC-D ("yes" response) or a RIC F ("no" response), saying yes or no to each request.
7. If premium payments are authorized by CMS, CMS sends the State a RIC-B billing file once monthly for all new clients and ongoing cases. This is a 1400 page COLD report used to ensure premiums are allocated correctly.
    a. There is a posting process that allocates and posts each incoming transaction to a matching person in MMIS.

Current Process Deficiencies, Workarounds, etc.:

1. When an individual cannot be matched in at least 7 out of 8 factors, the case if forwarded to a recon table. There another report divvies up the transactions into FFP and non-FFP buckets. This is what accounting and budget use to determine what amount to bill back to the Feds.
    a. R-380 is a report by transaction telling which codes came in and how many.
    b. R-390 divvies up matched and unmatched transactions into FFP and non-FFP buckets.
        i. Percentage of federal match depends on categories of eligibility. The 300% FPL people do not get any FFP on their premiums at all. They have a buy-in eligibility code of "M."
2. Data mismatch between county and federal data:
    a. The buy-in accretion program runs on Sunday night – the system categorizes clients and what they need.
    b. HIC number is entered.
    c. System identifies that buy-in is not occurring. (80-90% are system generated.)

d. Manual entries are required for the remaining 10-20% where something is missing, for example the HIC number, or the coding on the eligibility file does not fit the standard, or there is a problem with the posting logic.
e. If there is missing data, the accretion is done manually. The system does not re-crete if there is something missing.
f. Once mismatched data is fixed, it has to be uploaded manually.
    i. The mismatched data cannot be fixed at the State level. While the data mismatch is being sorted out. The county has to be the one to update the eligibility information – this is significant because there is not direct data entry into MMIS. The State cannot enter into CBMS. Counties are pretty quick to fix things, but when social security has the wrong information, the local field office cannot change the month or year of birth. They have to send it off to one of the SSA payment centers and this can take from 90 days to 6 months.
    ii. Medicaid pays for services where Medicare would have been the primary payer. This is a cash flow issue.
    iii. The mismatch prevents clients from receiving premium payments from Medicaid, and this is a huge financial burden on clients. Clients may have to make choices about food versus medication in this situation.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
County Correction Report CSR	Correction Report will be sent to counties on weekly basis identifying mismatched or incorrect data.	Allows counties to and prevent, find, and/or fix mismatches quicker. The impact will be fewer premium payments held up because of data mismatch with federal sources.
QI-1 program (Qualifying individuals)	Set to expire 9/30/07 – will be renewed last minute. The program has sunset every year since 2002.	If the program is not renewed by Congress, both the eligibility system (CBMS) and the buy-in system would need to be adjusted to exclude QI-1 clients from eligibility and buy-in. If Congress renews the program, no system changes would be needed.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Send State response to CMS	Sunday nights – automated – it is the state request to CMS.
Department of IT (DoIT) sends state request file to CMS	Mondays- done to request buy-in start or stop, or to notify CMS of a change in client's eligibility and/or state ID#. Federal government performs matches against state data to determine whether the state request is either accepted or rejected.

CMS sends the successful buy-in transaction to RRB, SSA, Civil Service	Daily- notifies the agency to either stop or start the deduction of the Part B premium and issue any refund due to the client.
Send Response file (part A and B) from CMS to MMIS	Thursday mornings – response regarding eligibility decision after federal matches made.
MMIS to CBMS	Fridays – send a limited version of the MMIS buy-in table (RICs B, C, D, F, & S) to CBMS. Update is displayed on CBMS. Also send the HIC number update (smaller file with the state IDs where the HIC numbers are updated in CBMS) – both from MMIS to CBMS.
BENDEX (from SSA) to CBMS	Daily sent over to CBMS. Data matched to determine eligibility.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Colorado does buy-in for both part A and part B.
- Since there is no HIPAA standard, Colorado uses HIPAA transactions to improve their business standards.
- Working on the fourth improvement CSR for this process.
- Colorado was the second state to comply with CMS's buy-in redesign.
- Colorado was the first state to choose daily data exchange.

PROCESS: PREPARE CAPITATION PREMIUM PAYMENT

Process Description:
The Prepare Capitation Premium Payment business process includes premiums for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the Maintain Member Information, retrieving the rate data associated with the plan from the Manage Provider Information, formatting the payment data into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction. The resulting data set is also sent to Manage Payment History for loading and Manage Provider Information for updating.

NOTE: This process does not include sending the capitation payment data set.

Process Description Corrections:
1. Maintaining member information = client database
2. Manage Provider Information = provider file
3. Capitation is not peformed for PCCMs, but are doing them for PIHPs – this includes Rocky and BHOs.
4. Generated on the first Saturday of the month, goes into capitation cycle and the payment is done on the following Friday. The 820s, etc. are generated later.

Current Process Deficiencies, Workarounds, etc.:

1. Contract signature date workarounds:
    a. When contracts are not yet signed, the State has to hold the payment until there is a signed contract.
    b. There is a "contract signature date" on the file. If set to a specific date, the system will not create a capitation payment beyond the date. The capitation date cannot be easily reset or managed. As a workaround, the capitation date is kept open in the MMIS and holds or other date adjustments are managed in COFRS.
        i. All capitation dates are open-ended in the MMIS.
2. Enrollment problems:
    a. The majority of deficiencies are related to enrollment, re-enrollment, or contract changes. Payment is not the source of most problems or workarounds. It is difficult to understand the source of many of these enrollment-related problems.
    b. Friday night they get information, go through managed care, capitation cycle, adjudication cycle, To-Be-Paid/To-Be-Denied status, but if check client information is not good, they go back.
    c. Capitations are created off of enrollment tables.
3. The state is looking at new models of managed care. The system is so complex that they have a lot of anomalies.
    a. The Colorado managed care system is not reflective of how the federal government handles managed care. Colorado is starting to move toward that model, which allows more flexibility and diversity.
    b. Clients in Colorado have to opt out of managed care. Clients must request to stay in fee for service programs.
    c. Paying Rocky is done by invoice within two days of the invoice. They still get a file of claims, but these are minimally verified. Because of that, and that those claims are not entered into a data repository, they cannot easily be analyzed.
4. CHP+ payments are adjusted by COFRS after the capitation is created and before it is released. COFRS and MMIS do not match. HCPF does not know why this adjustment is done.
5. There is not a way to pick up files automatically. After sending data to the file and report service, they cannot electronically pick it up. There is a manual start, and then the process is automated.
6. Retroactive voids are done through mass adjustments (MAs). Retroactive rate changes are difficult because the numbers are large. In the past, there have been problems with large MAs, but they have not had to deal with that recently.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Models of managed care potential	There are a wide variety of managed care models that Colorado does not presently support, but may in the near future. Included in this could be: • Including or excluding risk payments. • Managed care organizations doing their own network development, or not. • Paying some services and	Process and system would need to be more flexible to allow for additional managed care models.

	carving out others: ○ Behavioral health ○ Dental ○ Disability services	
CO Promise	CO Promise is being worked into the system. Will not be able to do the HMO like now. PIHP has a lot of problems. Managed care process is not set up the way the State would like it to be – may pay a case management fee and FFS. But if a vendor is doing PCM, they may want to pay them a capitation and lock the client into the "health plan." The State could process claims under a PIHP model like they do for FFS, but there are not the same edits and controls on the clients and the vendor does not have the management that they do elsewhere.	State would want to shuffle these responsibilities among vendors.
SB-208	Established a commission to discuss new ideas surrounding health care reform.	They have four plans and are working on a fifth to be presented in January. Some portion of the bill will be regarding managed care plan – if not all of it.
Federal level possibilities	Unknown.	There is a possibility of federal initiatives in this area, but it is unknown of what they would consist.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
MMIS creates and sends out capitation files to contractors. There are only outgoing information flows.	There are two primary files – capitations are sent (the notifications R-300 series reports – all of which are keyed off of the capitation cycle – new enrollees, discontinuation, enrollee summary and capitation summary report) and posted to the File Report Server and downloaded by vendors. This is a monthly process. Presently only Delta Dental is using the 820 and 834 on a regular basis. Colorado Health Partnerships are awaiting the change in order to use the 834 on a daily basis.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- HIPAA-compliant standards are used with the exception of PLA standard. Written it into the APD for the PIHP study that might result in systems changes.
- Do not deal with other insurance agencies.
- They have a modified claim adjudication process to support capitation payment preparation (Rocky would justify this).

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Operations Management

Assessment Session ID:	OM07
Session Date/Time/Location:	August 8, 2007 1:00 – 3:00 pm PK Offices
Date Updated:	August 15, 2007

Participant	Role
Steve Hunter	Not Present
Diane Dunn	Claims Section Manager
Steve Holland	HCPF IT Eligibility
Steve Nelson	Managed Care/ Pharmacy Supervisor
William Heller	Not Present
Carol Reinboldt	Fiscal Operations Manager
Timothy Maloney	Operations Quality Control Analyst
Nathan Culkin	FFS Supervisor
Dan Roderiguez	System Documentation and Interface Analysis

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Steve Hunter	August 15, 2007 (default)
Diane Dunn	August 15, 2007 (default)
Steve Holland	August 15, 2007 (default)
Steve Nelson	August 15, 2007 (default)
William Heller	August 15, 2007 (default)
Carol Reinboldt	August 15, 2007 (default)
Timothy Maloney	August 14, 2007
Nathan Culkin	August 15, 2007 (default)
Dan Rodriguez	August 15, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Manage Payment Information
Inquire Payment Status
Prepare Member Premium Invoice

PROCESS: MANAGE PAYMENT INFORMATION

Process Description:
The Manage Payment Information business process is responsible for managing all the operational aspects of the Payment Information Repository, which is the source of comprehensive information about payments made to and by the state Medicaid agency for healthcare services.

The Payment Information Repository exchanges data with Operations Management business processes that generate payment information at various points in their workflow. These processes send requests to the Payment Information Repository to add, delete, or change data in payment records. The Payment Information Repository validates data upload requests, applies instructions, and tracks activity.

In addition to Operations Management business processes, the Payment Information Repository provides access to payment records to other Business Area applications and users, such as the Manage Program, Member, Contractor, and Provider Information processes, via record transfers, response to queries, and "publish and subscribe" services.

Current Process Deficiencies, Workarounds, etc.:

1. For Fee for Service claims, payments to providers are managed through two systems:
    a. MMIS
    b. COFRS.

    When a claim comes in to MMIS and it is a paid claim, the amount is passed onto COFRS system. COFRS does own processing and creates a warrant (check) or an Electronic Funds Transfer (EFT). Some things are not communicated between the systems. If there is a collection from a provider that is not tracked by MMIS, MMIS may say that they will pay the provider $100, but COFRS may pay $50. In MMIS the pay amount is $100. COFRS sees this as a weekly file upload.
2. Payment is made based on tax ID. Multiple provider numbers may be linked to one tax ID. Combining payments for multiple provider numbers linked to one tax ID simplifies the process and reduces costs.
3. The financial cycle runs once a week (usually Friday night) and processes all the claims in one large batch. The financial cycle is then passed to COFRS through interface. COFRS pushes return data to MMIS and one week later, MMIS matches warrants to provider payments within COFRS.
4. Small problems with COFRS may create delays but do not necessarily resultin claims being processed manually.
5. Overpaying providers:
    a. The accounting department would ID the overpayment amount.
        i. This is tracked in MMIS, but not in claims processing.
    b. If provider owes $100, they may submit a check for $100 instead of having that amount taken out of future claims payments.
    c. The accounting department would then do a credit and a debit within the financial cycle.
    d. The check comes in to ACS and is given to the State who deposits it and creates a record in that area. This is done by a financial transaction, which reduces the provider's debt in the MMIS.
        ii. This part of the process is somewhat manual because accounting has to manually make the change.
    e. If the provider createx the accounts receivable (overpayment) by voiding previously paid claims, transactions are automatically created by the MMIS claims system to pull the amount the provider needs to repay from future claims payments.
        iii. The provider can send in a check as indicated to repay the A/R.

6. Returning warrants:
    a. ACS receives a returned check (due to bad address, etc.).
    b. The payment is researched.
    c. If ACS cannot find an address, the claims have to be voided through the MMIS and the payment needs to be voided/cancelled in COFRS.
        i. ACS has to void the claim because the provider never received the payment. This is needed to keep the budget accurate and to ensure the MMIS payables match the COFRS payables.

d. Once a check gets back to HCPF they send the check to the State Controller's Office who voids it in COFRS.

7. Fiscal-pend process:
    a. These payments are all Fee for Service and Managed Care payments that go through the Financial cycle and pay out. The MMIS can help manage the money through a fiscal-pend process.
    b. Cliams are pended if the account in MMIS shows that there is no money left.
    c. There is no over-expenditure in OAP-HCP – this helps double check them and eliminates dependency on COFRS for authorization.
        i. This is good because the State does not over-process and have to void claims, but it can cause problems when the State does not think through the consequences of not putting money when going through general ledgers updates (ledgers are the funding code kept in MMIS – with translation table for COFRS).
        ii. Coding strings are updated once a year minimally or as needed. They either 1) direct the claims to the appropriate place in COFRS or 2) mark the claims so that they know where to attribute them on CMS – 64.
8. Provider not in COFRS:
    a. COFRS has 2 files:
        iv. Master File based on tax ID.
        v. UM record (UM is the code for HCPF). AKA the Vendor record.
    b. When the payment file from MMIS is transferred to COFRS, if one of the providers who is going to be paid doesn't have a UM record, then the payment voucher rejects.
    c. HCPF monitors a spreadsheet listing providers with rejected payments, which is maintained by accounting.
    d. HCPF takes steps to ensure these providers do not continue to submit claims that cannot be unpaid through COFRS.
    e. HCPF voids the claims so the provider can re-bill.
        vi. The claims are voided out via transmittal. Voids are done weekly.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
COFRS to tax ID	This was a recent change where warrants and EFTs were combined to pay out by tax ID.	This change, which is already implemented, resulted in large efficiency gains.
Budget reductions Government Efficiency Management Study (GEMS)	Required people to use EFTs, rather than paper warrants. There are still a significant number of people refusing to use EFT because they are afraid the State will be able to remove money from their accounts.	There are large cost savings for the State if EFTs are used in place of warrants. It costs approx. $36 to process a check versus $3 to process an EFT.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
MMIS to COFRS	Weekly interface is done on Monday morning from Friday night's financial cycle.
COFRS	COFRS starts creating checks on Tuesday nights and by Friday, the deposits are posted through the

	ACH (automated clearing house).
COFRS to MMIS	Friday night/afternoon a tape containing warrants and EFT information posts EFT or warrant numbers onto MMIS and in 820 and 835 files.
Upload to COFRS	Weekly upload to COFRS with amount of money to be taken out of each warrant (if any) is listed. Process is managed by COFRS, and attendees did not know additional details.
File and Report Service (FRS) through web portal	Used to communicate payment information to providers. There are 3 reports/transactions that occur: 1) Provider Claims Report carries the amount of money the MMIS recommends COFRS pay, but not warrant or EFT information 2) 820 Transaction File 3) 835 Transaction File 820 and 835 transaction files carry EFT and warrant numbers as well as the amount the MMIS recommended COFRS pay. 820s and 835s are not posted until after COFRS to MMIS interface described above occurs. The provider claim report gets posted each weekend.
Provider adds and updates	Provider information is updated by provider management during the weekly MMIS to COFRS interface.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- This is primarily an electronic process.
- Although internal data must be mapped, the ability to compare data across programs has improved. COFRS to MMIS is done manually, with difficulty, and not automatically. Reporting is siloed.
- MMIS vs. COFRS – comparing across programs is program to program.
- Pharmacy POS – comes to MMIS for recommendation to COFRS and is all in one system.
- They do not have a rudimentary decision support system.
- Not at level 3 because coordination of benefits is not performed with 837s.

PROCESS: INQUIRE PAYMENT STATUS

Process Description:
The Inquire Payment Status business process begins with receiving a 276 Claim Status Inquiry or via paper, phone, fax or AVR request for the current status of a specified claim(s), calling the payment history data store and/or repository, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response, and sending claim status response data set via the Send Outbound Transaction process.

Current Process Deficiencies, Workarounds, etc.:

1. Rarely the web portal goes down. When this occurs, usually nothing can be done.
2. 276 and 277 inquiry processes are performed interactively through batch, AVRS, and the web portal.
    a. Available on the web portal since 2003.
3. There is no electronic response to paper or fax inquiries. The call center can provide information.
    a. The process is either all manual or all electronic.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
N/A		

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
File and Report Service (FRS)	Batch 277s are posted to the FRS and there is a 2-hour turnaround.
Web portal	Interactive claims inquiry.
AVRS	Providers without web access can inquire regarding claims using their telephones. There is no rollover to the call center. Rather a call center phone number is listed at the end for those with additional questions. If a provider has a fax number on file, a faxed response with eligibility information can be sent to the provider.

Current Business Capability:

Maturity Level: Level 3*

Rationale:

- Programs use a centralized automated electronic claim status, etc.
- Because MITA interfaces are not defined, it cannot be a proper 3, but the process is a level 3 in all other ways.

***Changed Business Capability Level to Level 2– based on State Self-Assessment Guidelines released by CMS after the meeting was held indicating "Must meet all criteria of the level". Because MITA interfaces are not defined, it cannot be a proper 3, but the process is a level 3 in all other ways.**

PROCESS: PREPARE MEMBER PREMIUM INVOICE

Process Description:
Due to tightening budgets and an ever-increasing population that is covered under the Medicaid umbrella, States began client/member cost-sharing through the collection of premiums for medical coverage. The

premium amounts are based on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment.

The Prepare Member Premium Invoice business process begins with a timetable (usually monthly) for scheduled invoicing. The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Maintain Member Information process for updating.

NOTE: This process does not include sending the member premium invoice EDI transaction.

Current Process Deficiencies, Workarounds, etc.:

1. This process is only applicable to CHP+ payments at present in Colorado.
2. Colorado does not invoice. The State sends a letter to clients indicating they owe a premium payment.
3. In order to be eligible for CHP+, clients must apply. If income is above a certain level, clients have to pay $25-$35 annually. CBMS determines premium amounts based on income level and family size. For those owing premiums, benefits are pended until premiums are paid. CBMS mails premium letters. The check comes back to a bank lock-box controlled by ACS (CHP vendor). A report is generated daily that indicates which clients have paid the fee. This is posted into CBMS. It is used by 1 or 2 ACS technicians who post fee payment on client records. At this point, the CHP+ benefit is authorized.
4. CBMS transfers the information to MMIS once premiums are paid. Applicants are not eligible until their premiums are paid. The MMIS does not see client information until eligibility is determined. Once client information is in the MMIS, it is assumed that premiums are paid.
    a. Applicants are pended in CBMS until premiums are paid.
5. Clients must respond to premium payment requests within a certain timeframe. Applications will be denied after that cutoff and applicants must reapply for benefits.
    b. Uncertain of timeframe for denial.
6. Posting client premium payment from bank records to CBMS is a manual process. The bank-generated report is worked manually by ACS CHP. ACS technicians manually go into CBMS records to note premium payment. This manual process is a quality assurance step that should remain in place.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Universal healthcare	Medicaid-like benefit that is paid by clients who do not otherwise qualify for care.	There is a potential for this type of benefit to come up in 2008 legislation. At this point, it remains hypothetical.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Report received from bank	Indicates who has paid the premium
Letter sent indicating premium owed	This is more of a process than an interface

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Do not have anything automated from the bank.
- All information can be viewed online.
- Notices are automatically generated sent on paper advising of hearing rights and the amount of their contribution.
- In Level 3, member liability amounts are not updated by MMIS – this is not a requirement of MMIS.
- CBMS is the accounting system for premium payments. They register the payments, and have never had someone overpay. Overpayments and crediting are not automatic.

Open/Parking Lot Issues:

1. If a client is currently on the system (MMIS) and owes a premium at renewal (for the second or any subsequent year on CHP+), what happens if the premium is paid late or not paid? The client should be pended and not allowed to access services, but this is not necessarily happening. (**Steve Nelson and Steve Holland)**
2. What are the timeframes taken to allow a client to pay the premium? Is there an automated process to deny the application if they have not paid the fee? Are the notices being sent and what are they saying? Are reminder notices sent?

Public Knowledge LLC
Management Consultants

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Operations Management

Assessment Session ID:	OM09
Session Date/Time/Location:	August 9, 2007 9:00 – 11:00 am PK Offices
Date Updated:	August 22, 2007

Participants	Role
Peggy Beverly	Claims System Business Analyst
Cynthia Oten	Claims System Programmer
Steve Nelson	Drug Rebate, Managed Care
Thomas Walsh	Decision Support System
Diane Dunn	Not Present
Gary Ashby	Benefits Coordination
Vincent Sherry	Drug Rebate
Mark Seevers	Estate Recovery and Third Party Recovery
Sandy Barnes	Program Integrity
Jed Ziegenhagen	
Catherine Traugott	

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Peggy Beverly	August 20, 2007 (default)
Cynthia Oten	August 20, 2007 (default)
Steve Nelson	August 20, 2007 (default)
Thomas Walsh	August 20, 2007 (default)
Diane Dunn	August 20, 2007 (default)
Gary Ashby	August 20, 2007 (default)
Vincent Sherry	August 20, 2007 (default)
Mark Seevers	August 14, 2007
Sandy Barnes	August 20, 2007 (default)
Jed Ziegenhagen	August 20, 2007 (default)
Catherine Traugott	August 22, 2007

PROCESSES REVIEWED IN SESSION:
Manage Recoupment
Manage Estate Recovery
Manage TPL Recovery
Manage Drug Rebate
Manage Settlement

PROCESS: MANAGE RECOUPMENT

Process Description:

The Manage Recoupment business process describes the process of managing provider recoupment. Provider recoupment are initiated by the discovery of an overpayment as the result of a provider utilization review audit, receipt of a claims adjustment request, for situations where monies are owed to the agency due to fraud/abuse, and the involvement of a third party payer.

The E2E business thread begins with discovering the overpayment, retrieving claims payment data from the Manage Claims History, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results from the Manage Provider Communication, applying refund in the system from the Perform Accounting Functions, and monitoring payment history until the repayment is satisfied.

Recoupments can be collected via check sent by the provider or credited against future payments for services.

Current Process Deficiencies, Workarounds, etc.:

1. Colorado has two types of recoupment:
    a. Third party liability
        i. TPL recoupments are within this contract. Third party recoupments are described in the Manage Recoupments description. This section will focus on audit and fraud. The process description above confuses the two (last sentence, first paragraph).
    b. Overpayment recovery from providers.
        i. The contractor conducts data matches to determine whether individuals are eligible for any other insurance. The majority of Colorado carriers have access to eligibility files where they can access the providers to determine who does what.
2. Fraud recoupment:
    a. Desk reviews are spurred by referral sources indicating potential fraud or other outlier behavior.
        i. SURS is used to determine questionable areas or outlier trends requiring additional research. Filtering through SURS is an automatic process, once the filters are set up. The recovery officer does this.
        ii. Business Objects (BOA) is used to gather detailed claim history.
    b. The Auditor's Office determines if an over-payment is due. If the State determines there was fraud, the case is referred to the Medicaid Fraud Control Unit at the Attorney General's Office.
3. Colorado contracts out oversight of certain areas:
    a. One contractor conducts data mining of pharmacies, dentists, and other large provider types. This contract just expired.
    b. Another contractor reviews hospital DRGs. This contract is nearing its end. To this point, there have been about a half million reviews.
4. Third party payers in home health require a workaround. The State manually has to see if clients have Medicare coverage, because there is no crossover/interface. The State performs desk audits to determine if Medicare should have been billed instead of Medicaid.
5. Most of this process is manual from the State and the Contractors' perspectives.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
State legislation last year	Required State to allow providers 45 days to produce records instead of 30. Legislation also gave providers the option of having a pre-final report conference before the final report.	Pre-final report conference creates administrative burden for the State.
Deficit Reduction Act	The department obtained affidavits from large providers saying that they have policies in place around fraud, waste, and abuse. The weakness is that there is no good way to verify that the providers have these policies and procedures in place.	None.
False Claims Act	It has not yet passed. Act would provide additional tools for recovery of false claims by providers.	Uncertain

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Business Objects (BOA)	Obtains information from MMIS.
Contractor Systems	Proprietary systems interfacing with MMIS data to obtain claims data.
SURS	Utilization review ithin MMIS.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- Process receives 837s; no electronic output.
- Recoveries are not electronic.
- Generally a manual process.

PROCESS: MANAGE ESTATE RECOVERY

Process Description:
Estate recovery is a process whereby States are required to recover certain Medicaid benefits correctly paid on behalf of an individual. This is done by the filing a lien against a client's real property or by filing a claim against a deceased member's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery affects permanently institutionalized individuals such as persons in a nursing facility, ICF/MR, or other medical institution and any individual receiving Medicaid benefits over the age of 55.

The Manage Estate Recovery business process begins by receiving estate recovery data from multiple sources (e.g., date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), generating correspondence data set (e.g., demand of notice to probate court via Send Outbound Transaction process, to member's personal representative, generating notice of intent to file claim and recovery exemption criteria) via the Manage Applicant and Member Communication process, opening formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim, conducts case follow-up, sending data set to Perform Accounting Functions, releasing the estate claim or property lien when recovery is completed, updating Member Registry, and sending to Manage Payment History for loading.

NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.

Current Process Deficiencies, Workarounds, etc.:

1. Colorado does not file liens against estates. Liens are only filed for institutionalized individuals, 55 or older, who are not likely to return home.
    a. The State determines an individual is not likely to return home. An individual can appeal this determination.
    b. The lien process is used to protect the State's interest; sometimes property disappears.
    c. The lien process is the same as the claim process described below.
2. Colorado generally files claims against estates in lieu of liens.
    a. Colorado uses a contractor for estate recovery. A listing of all the claims paid on behalf of all individuals is sent to this contractor. The estate recovery contractor maintains a database of institutionalized Medicaid recipients and recipients over 55 years of age along with records their Medicaid claims. The contractor conducts data matches against social security records, probate records, death records, etc. to determine if there is property available for recovery.
    b. Once a claim is filed, the court can allow or deny the claim.
    c. The contractor recovers the funds and transfers the money to HCPF accounting where it is recorded. This is a manual process.
    d. COFRS has the ability to identify estate recovery funds from other recoveries because HCPF needs to report to CMS on estate recoveries.
3. Probating an estate is a manual process. It is legal litigation and must be filed in court. The contractor compiles the claims data and other information used in the probate case. The claims information is derived from data provided to the contractor from the MMIS on a monthly basis and stored by the contractor.
4. Recording incoming checks is a manual process. Accounting is given information on the client and the recovery from the contractor. Every dollar coming in must be reconciled.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
New proposed state legislation in the next session	Will impact estate recovery, but details could not be discussed because it is still being created.	The impact will be substantial. It will make it easier for HCPF to recover monies.
Deficit Reduction Act	Affected estate recovery program through restrictions on assets and lengthening look-back periods.	It became harder for an individual to transfer assets before becoming eligible for Medicaid. The process itself was

		not changed.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Eligibility files (CBMS) and claims system files (MMIS) are transferred to the contractor in a monthly extract.	This data is used by the contractor and matched with external systems for estate recovery.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Contractor processes are automated.
- Extract sent to contractor is electronic.
- Check receipt and processing is manual. Should remain manual for quality assurance.
- Intake and budgetary inability to see the data – the budget people can get the information from the accounting department. There is a separate grant budget line (GBL) that they can view.
- The State does not have the capability of doing what the contractor does, but taking into account the contractor's abilities, the process is a 2.

PROCESS: MANAGE TPL POST-PAYMENT RECOVERY

Process Description:

The Manage TPL Post-Payment Recoveries business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, Attorney's, providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from Manage Payment History, creating post-payment recovery files, sending notification data to other payer or provider from the Manage Provider Communication process, receiving payment from provider or third party payer, sending receivable data to Perform Accounting Function, and updating payment history Manage Payment History.

NOTE: States are generally required to cost avoid claims unless they have a waiver approved by CMS which allows them to use the pay and chase method.

Current Process Deficiencies, Workarounds, etc.:

1. This process should not include SURS or Fraud and Abuse, because they are covered in Manage Recoupment process above. Fraud and Abuse may rarely provide information used in the TPL recovery process.
2. Colorado uses a contractor for TPL recoveries. Eligibility and claims data is sent to the contractor. The contractor conducts eligibility data matching with a variety of other databases to determine if another payer, such as private insurance, Medicare, Railroad Retirement, or the Veterans Administration, should have paid in lieu of Medicaid. Ninety percent of all insurance carriers in Colorado share their information with the State.
    a. For full recoveries:

   b. Once another payer is identified who should have paid, the contractor sends and Intent to Retract (ITR) notice to the provider who was mistakenly paid by Medicaid.
   c. The provider has 60 days to respond and demonstrate why funds should not be retracted.
   d. If the funds are to be retracted, the contractor sends a file to the fiscal agent to retract the claims.
   e. The fiscal agent adjusts the claims in the MMIS, recovering the money. The MMIS identifies where contractor recoveries/recoupments have occurred through adjustment reason codes.
3. The State manually conducts a quality assurance check on full recoveries. The State uses Business Objects to query recovered claims. This is matched against the file sent to the fiscal agent from the contractor. The two are manually matched, line-by-line.
4. Partial recoveries are a more manual process than full recoveries.
   a. The TPL contractor identifies partial recoveries and goes through the ITR process with providers.
   b. The contractor sends the state the information on partial recoveries.
   c. The State lists all claims to recovered on and the amount to be recovered. The state sends a transmittal to the fiscal agent requesting these partial adjustments.
   d. The fiscal agent adjusts the claims accordingly.
5. Correcting and error is a manual process requiring research and manual system adjustments.
6. Resolving disputes is also a manual process.
7. Updating the client resource file with third party information is also a manual process. When the contractor discovers third parties, they send information via secure data files and the State has to manually load the information into the client resource file.
8. Managed care performs its own recoveries. Managed care group can be hired and paid, but most don't do it so that their rates go up. If they collected, their rates would be reduced.
   a. This additional third party recovery process should be captured and ranked.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Deficit Reduction Act	Requires data matching and uniformed payment of claims, time periods. States are required to implement legislation to meet DRA requirements. All insurance company and managed care data would have to be shared with the State.	This legislation was not approved last session. It will be reintroduced this session. It will help the State identify more third party payers. Managed care data is difficult to obtain, so this will ease that process. The general process will not be changed.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Eligibility files (CBMS) and claims system files (MMIS) are transferred to the contractor in a monthly extract.	This data is used by the contractor and matched with external systems for recovery.
Contractor system to MMIS via file upload	ACS Pittsburgh uploads TPL contractor files of full recoveries to the MMIS.
BOA to MMIS	Manual query performed by State to find adjusted claims and match with file sent by TPL contractor of full adjustments.

Third party file used to update MMIS client information	Additional third party information sent to State from TPL contractor to manually upload to client resource file.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- The majority of Colorado's manual validation is for reconciliation and quality assurance purposes.
- The State has manual processes to update the client resource file and to recover partial recoveries.
- The contractor process is somewhat automated, but less so than for other recovery processes.

PROCESS: MANAGE DRUG REBATE

Process Description:
The Manage Drug Rebate business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes receiving quarterly drug rebate data from CMS, comparing it to quarterly payment history data, identifying drug data matches based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the Send Outbound Transaction Process sending to Perform Accounting Functions.

Current Process Deficiencies, Workarounds, etc.:

1. The State examines the quarter's data for adjudication.
2. The state sends the data to CMS.
3. CMS provides the contact information, rebate, and amounts.
4. CMS sends the data to the State.
    a. CMS sends quarterly tapes to the State of drug rebate information.
5. The State sends the tapes to the fiscal agent.
6. The State determines whether the monetary amount is worth recovering.
    a. If it is worth pursuing, the State can go to the drug companies and ask for the rebate.
    b. As the claims come through, the fiscal agent matches the rebate amounts to the drug names and produces a quarterly an invoice.
7. The tapes sent to the fiscal agent are obsolete technology, which could be improved upon. There are not any really manual processes that are done here.
8. Last November, the State went to DRAMS (drug rebate analysis management system), which cleaned up a lot of the manual processes. The remaining process is more of an actuarial accounting one, where an invoice is issued and if the manufacturer disputes, the issue may go to arbitration.
    a. Disputes are handled manually. If a remittance statement comes in, the invoice can be accessed and the money can be adjusted down to the penny if necessary.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Executive order for Preferred Drug List (PDL)	Drugs would be chosen to be preferred, meaning they would be prescribed more in Colorado	Supplemental rebates would impact DRAMS.

	than others, requiring prior authorization. Preferreds would be selected through a board-led process and influenced by rebate negotiations with manufacturers.	
Physician administered drug rebates	Rebates will be collected on inject-able and other drugs administered by physicians. The state will pick up their expired contractor's work on this topic in January.	Process should remain the same.
Deficit Reduction Act	Average Manufacturer Price (AMP) is supposed become the price States use to calculate drug costs, instead of Average Wholesale Price (AWP).	Process should remain the same.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
MMIS data sent to CMS	CMS looks at drug usage from claims.
CMS tape loaded to MMIS	Drug rebate information loaded from tape onto MMIS to create manufacturer invoices.
Between PDCS to DRAMS to CMS back to DRAMS and invoice it.	As the drugs come through, this makes sure that they understand what the drug is such that they can verify it with CMS. Validate these interfaces through Kevin Martin and Diane Dunn.
Problem of reading one system and recognizing another system. This timing and direct interfaces are important.	Talk to Kevin and Diane.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Systems electronically interface.
- Process is not manual.
- Invoices are produced automatically, but mailing, certifying, etc all are manual processes.
- Aid Drug Assistance Program (ADAP) is not in place.
- Systems are not interoperable

PROCESS: MANAGE SETTLEMENT

Process Description:

The Manage Settlement business process begins with requesting annual claims summary data from Manage Payment History, reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates, sending the cost settlement data set via the Send Outbound Transaction process to Manage Provider Communication, Manage Payment History, Manage Rate Setting and sending receivables data to Perform Accounting Functions, and tracking settlement payments.

Current Process Deficiencies, Workarounds, etc.:

1. This corresponds to how they pay hospitals for outpatient hospital services.
2. They reimburse hospitals through MMIS for outpatient services on an interim basis. This is based on the estimated costs.
3. After a hospital has their cost report finalized by Medicare (this takes years), they submit the report annually to CMS who then finalizes and approves it. Those finalized cost reports go to Jessica's contractor (Parish, Moody, and Fikes). The contractor takes the Medicare cost report and audits it for Medicaid purposes. There is a component of the Medicare cost report that is for Medicaid. This cost report is compared to the annual claims summary data that they receive from ACS.
4. The contractor would contact ACS and ask for the cost report for the year – broken out by revenue code. The report is a defined report that generates a standard form for all cost-settlements. They compare this report to what they pay the hospital through MMIS to what the actual costs were for that time period. They look at what was paid and what the actual costs were and the contractor finalizes this document and brings it over to the office with a letter breaking out what the settlement is. They notify the provider of what the difference is and then the provider responds.
5. There is a person who logs all of this and has it all in a spreadsheet. They bring in about $10 million a year.
6. The process aligns pretty well with the above description. The contractor goes to ACS and requests X number of hospitals claims for a specific time period – COLD, reviews provider costs in cost reports. Receives the cost report, calculates the final settlement, verifies the data, they notify the provider, there is someone who manages all of the payments and tracks it in the spreadsheet.
7. They have made a lot of revisions in the last year to improve things. There is a new report from ACS. The newer report is the most accurate that they have ever seen!
8. They have made a lot of changes and refinements to make it better.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Last year's legislation – AGs said it was affective at the end of May (2007).	Provider appeals legislation	How long the informal reconsideration process is. They revised the letters they send to the providers to make sure that they are in compliance with the law. They didn't have to respond with a letter before. The law mandates a response.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Transmittal process	Loading rates into the system to calculate the interim reimbursement – what goes through and what they pay. They write up the rate and the document and that is the process that ACS has established when a change is not a CSR. Transmittals are when they can update something. Transmittals get sent to IT, then to ACS. It's a paper document that they hand in (for rates) if a long list, they can email it, but often it's only one rate at a time. They have to send a manual letter in the formal process.
Contractors have access to COLD system	ACS generates the reports in COLD (large files). They notify the contractor when the report is there and the contractor can go in and see the payment break-down.

Current Business Capability:

Maturity Level: Level 2

Rationale:

- They have a standardized data set, and good reports.
- The cost settlement is done electronically. There are manual audits that they have to keep manual.
- HIPAA is not in play because they are analyzing financial costs of reports (not client information).
- This is mostly an automated process to the extent that it can be.

Public Knowledge LLC
Management Consultants

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Program Management

Assessment Session ID:	PG01
-Session Date/Time/Location:	August 15, 2007 9:00 – 11:00 am PK Offices
Date Updated:	August 23, 2007

Participants:

Catherine Traugott	Not Present – Follow-up meeting 8/22
Kimberly Eggert	Not Present
Jessica McKeen	Rates Section Manager
Margaret Mohan	Manage Acute Care Benefits
Barbara Prehmus	Division Director for Long Term Care Benefits
Laurel Karabatsos	Division Director for Benefits

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Catherine Traugott	August 22, 2007
Kimberly Eggert	Not Present
Jessica McKeen	August 24, 2007 (default)
Margaret Mohan	August 23, 2007
Barbara Prehmus	August 23, 2007
Laurel Karabatsos	August 23, 2007

PROCESSES REVIEWED IN SESSION:
Designate Approved Service/ Drug Formulary
Develop and Maintain Benefit Package

PROCESS: DESIGNATE APPROVED SERVICE / DRUG FORMULARY

Process Description:
The Designate Approved Services/Drug Formulary business process begins with a review of new and/or modified service codes or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package.

Service, supply and drug codes are reviewed by a team of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and state plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.

NOTE: This does not include implementation of Approved Service/Formulary.

Current Process Deficiencies, Workarounds, etc.:

1. By federal law, it's an open formulary. When a drug comes out, it is covered unless the federal law prohibits covering (if non-rebateable or part D). This will change for certain categories with the PDL (preferred drug list).
2. We cannot deny any drug to a Medicaid client as long as it is federally rebateable and approved by the FDA. What they can do is limit the access to the drugs through prior authorization, limitations, PDL, and generic mandate.
3. Currently there is not a review team, but they will move in that direction with the PDL. There is a team that is responsible for the formulary, but it does not work that way. PDL will change how they limit things. Right now they cannot deny it, they can only limit drugs. By federal law, they have to have the open formulary. They can limit through the restrictions, but at the end of the day, they have to be covered (this is federally mandated).
4. PDL is not affecting the open formulary idea. CO is one of the last states to get a PDL.
5. DME, supplies, physician visits, service formularies, etc.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
EO – 004 – 07	Moving to a PDL	The Department will have a lot to do to implement the PDL – system changes, hiring a contractor, supplemental rebates (not doing purchasing pool to get those), rules, State Plan Amendment. They are in the process of implementing this with the goal of early 2008 for the first drug class. Rules are not finalized to review PDL, proposing once annually. The rules go to the board in September 2007.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
ACS – FDB interface	Fiscal agent – rely on them to provide accurate formulary. They receive information from First Data Bank. This information drives the generic mandate that's been in place since 2003 as a legislative mandate.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- They only have one formulary, so they don't have siloed systems. They do have one for dual eligibles, but there is not a part D group vs. the regular Medicaid group. They cover Medicaid Part D excluded drugs to the extent that they are covered for all other clients.
- Centralized by the enterprise. Standardized systems are centralized by the benefit packages.
- Decisions based on fiscal impasse and regulatory requirements.
- Don't look at health outcomes when doing formulary – but they are not allowed to by federal law. On the back end – looking at PA, limitations, PDL, and federal law – these are done by clinical. Base formulary is done by law and they have to cover it. They look at clinical things to determine limitations and PAs. They rely on the system pieces to determine if it's a rebateable drug, but there is not necessarily clinical data available. They use utilization data (claims based process). Looking at overall condition of individual clients or even groups of clients from what they can glean from claims data. They look at the pharmacy claims data, diagnosis codes, but going beyond that is difficult. There is a disease management program, but there is not a pharmacy program with that.
- Communication of changes is done through the provider bulletin or posting on the website – these are both electronic.
- Limited analysis of heath outcomes as a determining factor.

PROCESS: DEVELOP AND MAINTAIN BENEFIT PACKAGE

Process Description:

The Develop & Maintain Benefit Package business process begins with receipt of coverage requirements and recommendations through new or revised: Federal statutes and/or regulations, State law, organizational policies, requests from external parties such as quality review organizations or changes resulting from court decisions.

Benefit package requirements are mandated through regulations or other legal channels and must be implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified. Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including:

- Determination of scope of coverage
- Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc.
- Identification of impacted members and trading partners.

Current Process Deficiencies, Workarounds, etc.:

1. Developing a benefit package and maintaining a benefit package are the two main divisions in the effort.
2. The level of effort involved with creating a benefit package is dependent upon the benefit(s) associated with the package. The process for developing a benefit is as follows:
    a. Potential benefits and/or package may be initiated by a legislative mandate. Potential benefits are sent over to the Department for a fiscal assessment. The benefit information passes a fiscal assessment by the IT Department and other stakeholders. The Department staff and stakeholders convene to decide what it will take to implement the benefit. Assumptions are either proven or disproved. The system and the benefit at hand are reviewed to determine the potential technical changes that may be necessary in order to process claims. Program staff, stakeholders, and others identify the makeup of the

benefit package including but not limited to the benefits, limitations, the practitioners who may administer the benefit.

b. Identification is accomplished through a series of meetings. For example, for the pediatric hospice waiver the Department worked through the process to submit the waiver: lay out and discussed the assumptions, and looked broadly at program eligibility. The waiver is then submitted to the federal government for review and approval. If the federal government approves the benefit, the Department moves forward with planning and implementation of the benefit package.
c. Program personnel then develop rules for the program, identify CPT or HCPC codes, and identify which providers will provide services. These decisions are made through a series of meetings that may include: the Fiscal Agent, the Department, CMS, etc. Through a collaborative effort, stakeholders contribute to determining what is needed to implement and execute the benefit package. Requirements are verbally discussed and then documented.

3. The process for which benefit packages are created is informal and relies heavily on experienced program personnel to raise the right questions and cover all the different areas of work. The process is difficult for new staff and people who have little experience with regard to creating benefit packages.
4. Since there is no formal standardized process, workarounds are identified in the meetings as necessary. For example, what was assumed a couple of years ago may not work today. IT's experience and knowledge regarding the system functional areas are relied on to prompt discussion in those key areas. When the benefits are brought up, they sometimes discover that they need to make edits.
5. There is a requirements document that ACS has created which leads the discussion and assessment of how the system may be impacted as a result of the proposed benefit package. By working through the requirements document, the State and other stakeholders are able to determine the level of impact on the system and the approach that will be taken (i.e., low effort fix, or requires CSR). If a CSR is required, the change will be scoped in detail to establish a cost estimate. If the CSR is approved by the State and their contractor, the CSR is prioritized and placed in the queue. The contractor's IT staff and the Department will then work to implement the change.
6. The actual updating (or modifying) of benefits at times can be automated in the MMIS. Codes may be adjusted or pricing changes may be applied systematically. Maintaining benefits (or adjusting them) is the second half of the process.
7. For example, CMS may release information associated with the particular service requiring the State to determine whether it will part of the Medicaid program and (potentially) update the benefit plan based on their decision. There may be an electronic import of code information from CMS, however there is manual intervention by State staff.
8. In some cases, some claims have to be priced manually. This is a workaround due to limitations of the current system. In this case, when a claim comes in, ACS applies the pricing manually to the invoice for payment. These manual workarounds do not occur very often. However, for DME, there is a large volume of claims that are priced by invoice. This allows ACS to keep current with invoicing when working with volatile prices until Medicaid sets the appropriate rate.
9. For other benefits, State staff looks at claims data in terms of analyzing how services are being utilized. This process requires manual intervention.
10. There are limitations on the edits that can be applied. If edits are necessary, text can be inserted to alert claims adjudication staff of necessary adjustments that need to be made in order to pay claims. This workaround occurs because ACS could not get the automation specific enough. As a result, the qualifier is loaded into the reso-text and each claim is reviewed manually.
11. Behind the scenes, there are other systematic benefit processes that are automated that ACS can provide more detail about. For example, rules that exist include: define benefit, load benefit, determine eligible providers, programs, etc. When the claim comes in, it must pass through these rules before it can pay. This happens automatically to either reject the claim, pay, or suspend it.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Ongoing legislative process	CMS, legislature, etc.	Always adding benefits or changing benefits, but there is not much policy that affects what they do. They don't often know what the legislature will mandate or what changes will be implemented. These changes do not necessarily change the process, it just adds a step.
DRG grouper (hospital reimbursement software)	Yearly load Oct. 1. ACS receives it in July.	Changes the way that things are taken on an automated basis.
DRA		Opened doors to different benefit structures so that there are some things that CO will be pursuing that they have not had before. It's still a federal piece of legislation that doesn't change how they make decisions on what's on the menu. It will also impact a lot of what they do on changes. Looking at what of the state rules, plans, etc. need to change based on what currently exists. They still have to evaluate all the pieces when they add a benefit.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Forms	The State is not the keepers of these forms – they appear to have a standard format. The Department's IT BA (from ACS and the State side who approves it and supervises it) raises key questions that need to be answered. Clean-up the following: IT recommends changes and the Program staff considers the changes and makes the decision. From the Program side, they know what they committed to from the Feds. The Program knows what that is supposed to look like. The potential for miscommunication arises when the IT personnel develop a set of paths to get to "X." Program personnel don't always know how to get to the desired result. Personnel focus on what they need at the end of the day. The desired result requires substantial effort from both IT and the

	program side. IT comes up with the "how" recommendation and the State will either approve it or work ACS to achieve the result that they need.
CMS Codes (import)	From CMS – maintenance piece.
CBMS giving eligibility information to MMIS to match	CBMS eligibility and MMIS benefits have to communicate so that the labels or tags are put on claims data so that they will be pulled in for the reporting requirements. PAs are necessary for some systems, and the communication between CBMS and MMIS must be complete in order for the proper information to be available at the right time to the right people.
Reporting EPSDT services to CMS	Takes claims that are processes according to these limits, counts them, and puts them in a spread sheet.
Reporting for CMS – accounting and EPSDT	Information from MMIS gets pulled into the spreadsheet (EPSDT 416) where they match eligibility and receipt of the benefit at the same time. Reporting might be in a different process. We are not sure.
Other systems that share information with MMIS – coding databases, etc?	Not with MMIS as much as with other CBMS systems. The only coding update comes from CMS (automated). The department generates the other ones. CBT is all feds. The codes come over and Theresa has to touch them, price them, and determine that it's not a benefit. This is similar to what comes over on the feds for Prescription Drug stuff (national rebate list) – and Medicaid cannot pay for a drug that's not on that list. The list comes periodically and the drugs may come on and off of the list. This information is synced with what's in the MMIS. Does it come from CMS or do we have to upload it?
CSR form	Customer Service Request

Current Business Capability:

Maturity Level: Level 2

Rationale:

- In waiver programs, you can choose a service from a variety of providers (individual or agencies); there are different kinds of providers for a service that an individual client may choose. They can also choose home or away from home, etc. Behind the scenes, the system accommodates these choices. Depending on which choice the client makes the provider bills accordingly.
- For traditional Medicaid, they have certain criteria, and then there are specifications for waivers that occur.

- Not level one because there are not just a few packages. They offer a lot of packages unless on specific eligibility (specific and systems driven, which is not necessarily how things are done).
- Looking at the flexibility of the system. IT would need to be here to determine what exactly occurs. IT would help do the workarounds (for example, can't have clients in HMO and in 'x' program…)
- L2 is what they think. IT needs to confirm this.
- There are some elements of level 3 that are applicable because individuals are making choices across benefit packages based on clinical data, member preference, health status, etc. These are not automated packages, but they are still able to make these decisions.

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Program Management

Assessment Session ID:	PG03
Session Date/Time/Location:	August 14, 2007 9:00 – 11:00 am PK Offices
Date Updated:	

Participant	Role
Adel Soliman	Not Present
Juanita Pancheco	No Present
Peter Strecker	Not Present
John Bartholomew	Not Present
Sharon Hill	MMIS Budget Analyst
Roberta Lopez	Manager of IT Contracts and Monitoring
Diane Zandin	Contract Administrator
Diane Dunn	Not Present
Nathan Culkin	Claims System Analyst
James Coghlan	Director of Procurement

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Adel Soliman	
Juanita Pancheco	
Peter Strecker	Not Present
John Bartholomew	Not Present
Sharon Hill	August 15, 2007
Roberta Lopez	August 17, 2007 (default)
Diane Zandin	August 17, 2007 (default)
Diane Dunn	Not Present
Nathan Culkin	August 17, 2007 (default)
James Coghlan	August 17, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Manage Federal Financial Participation for MMIS
Manage State Funds
Manage 1099s

PROCESS: MANAGE FEDERAL FINANCIAL PARTICIPATION FOR MMIS

Process Description:
The Federal government allows funding for the design, development, maintenance and operation of a federally certified MMIS.

The Manage Federal Financial Participation business process oversees reporting and monitoring of Advanced Planning Documents and other program documents necessary to secure and maintain federal financial participation.

These are the types of functions within this business area but this does not appear to be a stand-alone process.

Current Process Deficiencies, Workarounds, etc.:

1. This is primarily a manual process. The budget process dictates the amount of general and federal funding the state has permission to draw down. They manually identify the projects that would qualify for an APD. APDs are then created manually. They manually track the portions that are utilized (at least the contractor portions). The contract administration, the MMIS administration and operations are all manually tracked with spreadsheets.
2. Reports are manually generated based on the budgets and associated information needed, with the exception of claims payment data.
3. MMIS tracks all funds that are spent toward a particular appropriation. The system does not break any of this information out; state versus federal expenses. Those expense breakdowns are done manually.
4. There is a two step process associated with the federal funding request and tracking dollars. It depends on the information that Diane and Roberta have based on the APD process with CMS. The state follows up on what they are able to approve. Budget will then ask the legislature to provide funding by writing a formal document and submitting it to the joint budget committee. They either approve or deny it.
5. The funding process starts with the general assumption of a percentage match (CMS/State). They hope that CMS will approve a larger percentage. If this happens, they change the percentage in the document to match the percentage amount that CMS provides.
6. Submitting invoices to accounting is also done manually. There are certain codes that are mechanized in the accounting system. These codes allow them to write one check and send it through the accounting system with certain portions of it attributed to certain projects and sources. That information is also captured via the CMS-64 (gets reported to the feds on this form). This report is done quarterly. Before the CMS 64 process, the budget group turns in the CMS 37 which forecasts the budget needs for approval (this is done quarterly at odd times of the year – February, April, etc.).
7. There is the claims side of this process which is more automated and systems oriented.
8. Some services get funding from designated cash funds which are considered state funds to be matched with federal funds.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Executive Order 16 – signed and effective as of May 2007, but implementation has been delayed. The state is working to inform people of this order and its ramifications.	Governor's order for all agencies to submit IT project plans to OIT for prior approval. This will then be incorporated into the contracting and APD processes. The final process definition has not been received from OIT, so they are still trying to figure out the exact effect.	This is a state requirement, but it will have to be incorporated into the APD process. CFR 611 - 619. There is a website for submitting projects. The turn-around time is 5 days. So long as the project is approved, it should not hold things up. However, this is the first year of implementation so they will approve most projects. The purpose of EO 16 is to consolidate expenditures. After

		this year, some projects will be asked to wait so that multiple purchases can be made together. The threshold is $10,000. And there is only 1 person reviewing the information at OIT. The purpose of this order is to align IT purchases with state goals.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Budget tracking spreadsheet	Tracks all expenditures for MMIS contracting – one for every contract. Tracks administrative costs for MMIS.
MMIS generates COLD reports	MMIS generates COLD reports for Claims Expenditures.
Spreadsheets	Internal tracking and monitoring.
Invoicing	Manual. Logged expense in spreadsheet, print, sign, goes to accounting where it is entered into the financial system (COFRS).
Emailing	Used to communicate, confirm, and document decisions made.
Tuesday morning meeting spreadsheets	Spreadsheets produced indicating the number of claims. There are monthly reports where they can see what they are purchasing, but these are drawn down manually to their own locations for trending. This does not tie directly into the expenditures and does not have any great impact to the process. Statistics (such as claim volumes) and timeliness are presented in these meetings.
Tracking Claims	There are operational decisions made based on change services requests where some result in ways that they track various types of claims that have occurred. Some have special funding that has been set aside and others are just part of general funding for MMIS. Even though John's spreadsheet does not itemize the costs, the other cost is in there either built into the contract or as special funding as a part of the contract.
CSR tracking	CSRs that have special funding go through the contract process. When the invoices come over, they verify that the services were rendered and that things are working properly. They pay the invoice and they track this back to the contract management piece and that goes back to the APD.

Status report	For APDs issued, there are monthly and quarterly status reports that are developed and submitted to CMS. OIT status reports are separate reports that are not dependent on the APD.

Current Business Capability:

Maturity Level: Level 1

Rationale:

- The process is manual.
- There is not OCR or AVR.
- They do not have point-to-point or wrapped connectivity or interfaces.
- Transactions are not received through EDI. They are paper, not electronic.
- Electronic invoicing is not done either.
- APD process is also manual.
- CMS 37 and 64 are submitted electronically, but populating those reports is totally manual.

PROCESS: MANAGE STATE FUNDS

Process Description:
The Manage State Funds business process oversees Medicaid state funds and ensures accuracy in reporting of funding sources.

Funding sources for Medicaid services may come from a variety of sources and often State funds are spread across administrations. The Manage State Funds monitors state funds through ongoing tracking and reporting of expenditures.

These are the types of functions that may occur within this business area, but this does not appear to be a stand-alone process.

Current Process Deficiencies, Workarounds, etc.:

1. This process is very similar to the Manage Federal Funds business process in terms of it being a very manual process. The difference lies in the production of the federal report. Federal match funds cannot be obtained without matching state funds.
2. A fully state funded program would bypass the APD process. With FFP, a portion is state-funded. Blended is when there is matching of the FFP. The state manages state funds the same way that they manage federal funds—they are monitored and tracked.
3. There are some programs that are entirely state funded—no federal dollars. They do not have to include the feds in terms of reporting on these programs.
4. There is a revised process in budget and accounting – they wait and see what the feds will pay. Then, they come up with the difference. The approach is to determine what they think or know that the feds will not pay for.
5. There are some programs for which the feds will never pay. For example, Colorado has funding for non-citizens. The feds will not pay for this, so it's all state funded. They approach this by looking for what's left-over.

6. Two processes are included:
   1) State funds and FFP matching
   2) State funds only which bypass the federal processes such as OAP-State only. The interpretation of 45 CFR 611 currently states that any time that the state increases the base contract amount, they must update the APD. CMS will approve a state fund only program, but the APD must be amended. However, the expenses paid for by state funds do not need to be included on the CMS 64 since it doesn't require federal funding. This information is also excluded from the CMS 37 forecast report.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
CMS's interpretation of 45 CFR 611	Any time that the state increases the approved cost associated with a fiscal agent, they have to go through CMS because the new monetary value exceeds what was originally granted.	The APD has to be amended. Prior contract approval must also be sought.
Executive Order 16	See above.	

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
Spreadsheets – see above.	

Current Business Capability:

Maturity Level: Level 1

Rationale:

- It is a manual process. There is not an OCR, or any electronic means of tracking the process. Though for claims they do have the automated process, but even for them, MMIS does not distinguish what goes where.
- Clinical data does not necessarily enter into the management of state funds. It is used to evaluate the use of state funds, but not to manage them. Clinical data refers to the PA process of claims.
- They use MMIS for tracking and reports for audit purposes. They have a specific person who audits claims using MMIS and other systems.
- **Please note for CMS:** L1 in this matrix assumes that because it's a manual process it is inefficient. This is not necessarily true in all cases. L1 does not fully or accurately support the business process description. The L1 description appears to measure the program not the funding of the program and therefore, it feels irrelevant.
- The 2nd, 3rd, 4th paragraphs of L1 do not seem to apply to the management of state funds business process. Therefore, this business process is a level one with the exception of the three bottom paragraphs.

PROCESS: MANAGE 1099s

Process Description:

The Manage 1099s business process describes the process by which 1099s are handled including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single social security number or tax ID number.

The Manage 1099s process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Manage Settlements process.

The Manage 1099s process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are researched for validity and result in the generation of a corrected 1099 or a brief explanation of findings.

Current Process Deficiencies, Workarounds, etc.:

1. This is an accounting function done through COFRS. The appropriate subject matter experts are not present to accurately cover this particular topic. Adel (department controller) and Juanita (accounting manager for the department) are the appropriate subject matter experts. Follow-up meetings will be scheduled.
2. Department of Personnel and Administration (DPA) is where the State Controller's Office is located – this Department sets the procedures for all departments for 1099s and other processes. The State Controller's Office generates the 1099s.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose

Current Business Capability:

Maturity Level: Level X

Rationale:

Public Knowledge LLC
Management Consultants

COLORADO MITA BPM ASSESSMENT
ASSESSMENT MEETING AGENDA
Program Management

Assessment Session ID:	PG07
Session Date/Time/Location:	August 16, 2007 9:30 – 11:30am PK Offices
Date Updated:	August 24, 2007

Participant	Role
Diane Dunn	
Nathan Culkin	
Thomas Walsh	
Joan Welch	Not Present
Peggy Beverly	Not Present
Teresa Knaack	Not Present
Vernae Roquemore	Not Present
Carol Reinboldt	Not Present
Jenny Nickerson	
Tim Maloney	
Laurie Stephens	QA of Transmittal Process

Review & Approval Section.

PARTICIPANT NAME	REVIEW & APPROVAL DATE
Diane Dunn	August 24, 2007 (default)
Nathan Culkin	August 24, 2007 (default)
Thomas Walsh	August 24, 2007 (default)
Joan Welch	Not Present
Peggy Beverly	Not Present
Teresa Knaack	August 23, 2007
Vernae Roquemore	Not Present
Carol Reinboldt	Not Present
Jenny Nickerson	August 24, 2007 (default)
Tim Maloney	August 24, 2007 (default)
Laurie Stephens	August 24, 2007 (default)

PROCESSES REVIEWED IN SESSION:
Maintain Benefit/ Reference Information
Generate Financial and Program Analysis Report
Support Contractor Grievance and Appeal

PROCESS: MAINTAIN BENEFIT / REFERENCE INFORMATION

Process Description:

The Maintain Benefits/Reference Information process is triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter or Price Claim/Encounter. It can also be triggered by the addition of a new program or the change to an existing program due to the passage of new state or federal legislation, or budgetary changes. The process includes adding new HCPCS, CPT

and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Prospective & Current Member Communication, updating/adding provider information from the Manage Provider Information, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the Receive Inbound Transaction.

Current Process Deficiencies, Workarounds, etc.:

1. Regarding the addition of new HCPCS codes: if a rate is available by Medicare, they are set at 75% of Medicare. If there is no rate, then they would bill by invoice until the rate comes through from Medicare (who sets rates by RBRVS – Resource Based Relative Value Scale). The rates are updated electronically using the process established by CSR 1818.
2. New HCPCS are received quarterly and annually. Quarterly updates are posted on the CMS website. Annual updates are e-mailed to state Medicaid agencies directly from CMS prior to being posted on the website. With new HCPCS, there are sometimes new modifiers. This depends on the services offered. The addition of new modifiers requires a CSR.
3. CPT codes are updated annually.
4. CMS provides an electronic spreadsheet for CPT codes. The codes come in a complete package, but state staff must go through each code and determine whether it's a benefit or a percentage. The files are e-mailed to state Medicaid agencies directly from CMS. The files are loaded electronically into the MMIS by ACS systems staff, and certain fields are automatically populated using the information contained in the CMS files. State staff populate the remaining fields using the automated process established by CSR 1818.
5. Once the rate is set by CMS, it is not reset.
6. Revenue codes are handled by Teresa K. Updates or additions to the revenue file are processed manually through a transmittal on the revenue file. Inpatient revenue codes and outpatient revenue codes are set up by ACS. The system requires that the current MMIS handles only 3 digit revenue codes, and revenue codes have been 4 digits for 10 years. This is a problem because HIPAA transactions require a 4 digit code. They have a transition process of removing a digit and then adding it back to the revenue code. This part is done automatically, but it's still inefficient.
7. Reference file updates are handled through transmittals.
8. Updating/adjusting existing rates is also done through transmittal (a cover letter is also included which contain directions associated with the attachments. Transmittals occur frequently and do not require CSRs. The transmittals, however, do become an official part of the contract with ACS. There is a spreadsheet that Teresa uses to indicate the span of dates. This is done through CSR 1818 that initiated the automatic updates. It takes it from the spreadsheet that automatically updates the MMIS. This is a two-part process.
9. In updating/adding member benefits, procedure codes, which could be considered benefits, are added. The communication to the members/clients is done through the providers who then have to communicate the new benefits to the clients. They add the benefits by adding procedure or revenue codes. If a new program is added (CDCE, for example), there is a process to add a new package. The everyday procedures are added through a HCPCS, CPT, or through managed benefits. The clients do not have direct information about these things. New CPT codes are added into the MMIS manually, but the codes are not listed as a benefit. Later, in the automated process, she can switch that on and it will work. Every code is in the MMIS system, whether they use it or not.
10. Provider specific rates exist (a code that is different depending on the location, qualifications, etc. of the provider). They are also done through transmittals. Nursing facilities also fall into this category. The rates have to be updated through program staff and must be done through transmittal.
11. Drug formularies are done through First Data Bank, an interface. The frequency of updates depends on several factors. There are quarterly full file refreshes and potentially weekly updates. First Data Bank is supposed to carry all major pricing pieces (AWP, Federal cost, ingredient cost, etc.); however

First Data Bank does not carry state cost or average manufacturing prices (AMP). The AMP is not known, and there is a struggle to define it. The interface is done electronically into the PDCS (prescription drug claim system). For State MAC (Medicaid Allowable Cost), there is only one drug. These updates can be done through transmittals.

12. Benefit packages include new programs created by the state. They must seek special approval. Either they provide the services or they don't. When discussing new benefit packages, they are adding a type of waiver. Substance Abuse completed a state plan waiver last year. There was a change request involved.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
Tele-medicine SB 06-165	This bill deals with the practitioner side of telemedicine (where clinicians and doctors can provide the service at a remote location). This will become effective Oct. 1, 2007 for the additional payments of transmissions. They have only started to have the authority to set transmission rates – adding a modifier and code to track it.	Adding rates to the HCPCS codes
SB 07-196	Home health HCBS	There will be additional combinations set up with pricing. This will not go in at the same time, it will be going in around Spring of 2008.
CO Promise	CO Promise indicates that "We will use IT to become more efficient in services." This effort will include telemedicine and interfaces.	
Medical Home	Philosophical designation for a provider. It is not a new code, not a new rate, and not a new managed care program.	
DRA		Impacts in AMP drug pricing.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
The CMS website provides an electronic spreadsheet for quarterly HCPCS updates and e-mails the annual HCPCS and CPT code files directly to the state Medicaid agencies.	The codes come in a complete package, but state staff must go through each code and determine whether it's a benefit. They have to populate fields that are not included in the CMS file using the automated process established by CSR 1818.
Updates or additions to the revenue file are manual through a transmittal on the revenues file.	Inpatient revenue codes and outpatient revenue codes are set up by ACS. There is a system

	limitation that the current MMIS handles only 3 digit revenue codes, and revenue codes have been 4 digit for 10 years. This is a problem because HIPAA transactions require a 4 digit code. They have a transition process of removing a digit and then putting it back on. This is automatically done, but it's still inefficient.
Updating/adjusting existing rates is also done through transmittal (a cover letter that gives direction to ACS to what to do with the attachments. It is an operational, everyday occurrence. It is not a systems change, so programmers, etc. do not have to be involved. The transmittals, however, do become an official part of the contract with ACS.).	There is a spreadsheet where Teresa can indicate the span of the dates. This is done through the CSR 1818 that initiated the automatic updates. It takes it from the spreadsheet that automatically updates the MMIS. This is a two part process.
New CPT codes are added into the MMIS electronically using the files received from CMS. Many fields are populated at this time from the CMS file, and others are set at default values established by the Department.	Later, in the automated process, Teresa populates the remaining fields and adjusts selected fields set to default values as needed. Every code is in the MMIS system, whether they use it or not.
Drug formularies are done through First Data Bank, an interface.	The frequency of updates depends on several factors. We think that there are quarterly full file refreshes and potentially weekly updates. First Data Bank is supposed to carry all major pricing pieces (AWP, Federal cost, ingredient cost, etc.); however First Data Bank does not carry state cost or average manufacturing prices (AMP). The AMP is not known, and there is a struggle to define it. The interface is electronic into the PDCS (prescription drug claim system). For State MAC (Medicaid Allowable Cost), there is only one drug. These updates can be done through transmittals.
Spreadsheet from CMS – In 2004, there was a spreadsheet method to load MMIS. This process may receive information directly from CMS, but we think that it comes to the department updated and then uploaded. This is 4-6 week process to do the end of the year update (CPT codes and HCPCS).	Annual code update process: 1) CMS e-mails the electronic files to the state Medicaid agencies 2) ACS systems staff run the jobs required to load the CMS files into MMIS 3) Certain fields are populated from the CMS file and others are set at default values established by the Department 4) Teresa consults with Department program staff to determine which codes are covered Medicaid benefits (this is the "manual" process 5) Teresa populates the remaining fields and adjusts selected fields set to default values as needed using the automated process established by CSR 1818
First data bank to PDCS	The frequency of updates depends on several

	factors. We think that there are quarterly full file refreshes and potentially weekly updates. First Data Bank is supposed to carry all major pricing pieces (AWP, Federal cost, ingredient cost, etc.); however First Data Bank does not carry state cost or average manufacturing prices (AMP). The AMP is not known, and there is a struggle to define it. The interface is electronic into the PDCS (prescription drug claim system). For State MAC (Medicaid Allowable Cost), there is only one drug. These updates can be done through transmittals.

Current Business Capability:

Maturity Level: Level 1* but these descriptions are not entirely accurate.

Rationale:

- Some proprietary EDI would be the spreadsheet exchanges.
- They have standardized data in the sense that they utilize national codes.
- Clinical data is rarely the basis for decisions because it is not necessary. The maintain benefits reference information does not appear to connect to the process description. Program integrity would be with medical records.
- Customers have difficulty accessing information – rather, they cannot access information on procedure codes at all.
- Communication for members is not done really either.
- They are increasing use of electronic interchange. Not doing OCR.
- Do have AVR, but not in relation to maintenance.
- Agencies are centralizing common process to achieve economies of scale.
- They improve rule application consistency in the utilization of the spreadsheets.
- These matrices do not really tie back to the description above.
- In the absence of other information, they are a level 1.

PROCESS: GENERATE FINANCIAL AND PROGRAM ANALYSIS / REPORT

Process Description:
It is essential for Medicaid agencies to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to the intent of the legislative laws or Federal reporting requirements.

The Generate Financial & Program Analysis/Report process begins with a request for information or a time table for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy),retrieving data from multiple sources, e.g., Manage Payment History; Maintain Member Information; Manage Provider Information; and Maintain Benefits/Reference Repository; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the Send Outbound Transaction for generation into an outbound transaction.

NOTE: This process does not include maintaining the benefits, reference, or program information. Maintenance of the benefits and reference information is covered under a separate business process.

Current Process Deficiencies, Workarounds, etc.:

1. There are various financial and program analyses.
2. This is performed primarily within the MARS system (the management administrative reporting system). Reports are both manual and automated.
3. Through MARS, they provide financial and program analysis in the sense that they know how many services can be accounted for (quantitative) and budgetary controls. In addition to the federally required GSD reports, they have built CO specific reports that assist them much better.
4. The most frequent report is the MARS 4600. Reports what they paid. There will be a companion report that shows eligibility and enrollment.
5. There are eligibility types that carry information. These are based in state budget with some correlation to the federal types, but they are not as good as they could be. There is also the Medical Statistical Information Set (MSIS) that goes quarterly to CMS – this gets at federal categories and federal eligibility types. This is somewhat automated. The interface is system generated, but is stored on tapes as per federal regulation. MSIS comes from the MMIS only and is on a very specific file layout with the inpatient record. It is a standardized flat file that has information on it with error codes, etc. CMS uploads this and uses it because it is the same information for all states that they can utilize for statistical analysis. MSIS is a way of standardizing information across the states. This is all claims data from MMIS. The eligibility information comes from the eligibility part of MMIS. There are 5 files: inpatient, other, LTC, drugs, and eligibles. This is an automated process. It goes on tapes, but they have been "100% electronic" since FFY 1999.
6. CMS-64 is a financial report that is important in terms of what services are provided, how they report, where they report, what they are audited on, etc. This is a hard copy report. They provide information to accounting electronically. This is delivered manually to the fiscal agent (ACS).
7. Waiver reports (CMS – 372) are reports of cost effectiveness of HCBS programs. These are automated, printed on hard copy and submitted to the feds on hard copy .
8. Reports are generated by MMIS, MARS and SURS automatically. Information is delivered electronically from MMIS main frame to a staging area where the reports are stored in a text format on the report manager application (a COLD application). The reports stored on COLD are then available to the users. There is a file upload into the COLD server.
9. Simultaneously with the MARS subsystem, a lot of files are sent out (discussed in the recovery meeting last week). They do have some files that enter the decision support system that perform a lot of financial and program analysis.
10. The Decision Support System (DSS) is frequently used to respond t o requests for information. MARS produces the same report monthly. The DSS would change certain features or criteria based on the time-frames. MARS is good for static reporting. DSS is good for ad-hoc, reporting. DSS is where most program analysis comes from.
11. They have processes that define the report content and frequency. The DSS reports can be delivered in several media options.
12. In the DSS, when issuing reports to people who are only allowed access to aggregated data, they do it by a HIPAA region basis (combined counties that are big enough to provide for aggregation so that there is not a violation of privacy).
13. They can receive payment, client, provider, reference information and combine into a single report or output.
14. Deficiency: In MARS, they cannot analyze health needs and outcomes. If you want to add something to a report, it must be done through a systems change request. The new report that will have eligibility and enrollment started in April and they won't have it completed until October. Many buckets of data are involved in getting this together.

15. There are a lot of workarounds done with the DSS. DSS is a querying system, not a transaction system. MMIS is a transaction system and can do discreet person by person calculations. There is strength in doing the transaction level processing for doing specific data.
16. There is not a 100% match between systems because the systems each have different strengths. DSS is fast, iterative, etc. MMIS is better at transaction level evaluations and calculations.

Known Policy, Legislative, or Other Impacts to the Current Process:

Policy, Legislation, Initiative	Short Description	Impact to Process
CO Promise – Gov. Ritter's platform. This is a 50 page document dealing with issues he identified that need to be addressed through the administration. It is an idea of what his administration is going to try to do. It is an executive mandate through Joan Henneberry. There are legislative and judiciary efforts that need to occur. More of a philosophy than a legislative agenda. Charge to become more efficient through IT.	HCPF must assure that they are meeting the healthcare needs of the population of Colorado.	HCPF is for the entire state. They are not one agency or another; it's more than just the medical programs they are currently funding. As they move forward, they need to determine the health needs of the entire state. This will be a cultural shift. Further, there is a lot of work that needs to occur for the regionalization of healthcare information through CORHIO (CO regional heath information organization). CORHIO is not legislative.

Interfaces and Other Independent "Medicaid" Systems:

Interface / External Systems	Purpose
MARS (Management Administrative Reporting System)	MARS provides financial and program analysis in the sense that they can quantify services and budgetary controls. In addition to the federally required GSD reports, they have built CO specific reports that assist them much better.
MSIS	The Medical Statistical Information Set (MSIS) goes quarterly to CMS and contains federal categories and federal eligibility types. This is somewhat automated. The interface that is system generated, but it goes on tapes (as mandated by federal legislation). MSIS comes from the MMIS only and is on a very specific file layout with the inpatient record. It is a standardized flat file that has information on it with error codes, etc. CMS uploads this and uses it because it is the same information for all states that they can utilize for statistical analysis. MSIS is a way of standardizing information across the states. This is all claims data from MMIS.

	The eligibility information comes from the eligibility part of MMIS. There are 5 files: inpatient, other, LTC, drugs, and eligibles. This is an automated process. It goes on tapes, but they have been "100% electronic" since FFY 1999.
CMS - 64	CMS-64 is a financial report that carries a lot of weight with the feds in terms of what they are providing services, how they report, where they report, what they are audited on, etc. This is a hard copy report. They provide information to accounting electronically. This is delivered manually to the fiscal agent (ACS) in a big pile of paper.
CMS -372	Waiver reports (CMS – 372) are reports of cost effectiveness of HCBS programs. These are automated, printed on hard copy and submitted to the feds on hard copy (but they are not that long).

Current Business Capability:

Maturity Level: Level 2

Rationale:

- Meet L1 without a problem.
- Business process is increasing its use of electronic interchange and automated processes.
- They are not using taxonomies because it's difficult to obtain. They do have things that allow for cross-state information exchange because of the emphasis on CMS-64.
- "Agencies" plural is not relevant. There is a single state agency that administers the Medicare program. They all use the same codes within the MMIS.
- L2, but tapes are still required by CMS.