Colorado Department of Health Care Policy and Financing

MITA State Self-Assessment Report

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Section 1 – Executive Summary

The Centers for Medicare & Medicaid Services (CMS) introduced the Medicaid Information Technology Architecture (MITA) as a framework to assist states with improving the operation of their Medicaid programs. A State Self-Assessment (SS-A) documenting the State's maturity level for each defined business process is a prerequisite for requesting enhanced federal funds to improve the Medicaid enterprise.

Public Knowledge completed this SS-A, in collaboration with the Colorado Department of Health Care Policy and Financing (the Department). This assessment is based on MITA Framework 2.01, released by CMS in 2009. It is focused on a review of the Business Architecture presented in the framework. It identifies the current "As Is" capabilities of the Colorado Medicaid program, assesses the future "To Be" level of capability, and provides a roadmap for achieving the future maturity level.

1.1 What Is MITA?

CMS introduced MITA as an initiative to help states improve the operation of their Medicaid programs. The MITA initiative began in 2005 with the concept of moving the design and development of Medicaid information systems away from the siloed, sub-system components that comprise a typical Medicaid Management Information System (MMIS) and moving to a service oriented architecture (SOA) framework for designing Medicaid information systems, with the understanding that business processes inform and drive the implementation of business services. The MITA initiative produced three architecture frameworks – business, technical, and information – along with a business maturity model for process improvement. The maturity model guides the planning of technology and infrastructure build-out to meet the changing business needs of Medicaid programs. MITA enables state Medicaid enterprises to meet common objectives within the MITA framework while still supporting local needs unique to the particular state.

The MITA is a 'work in progress' framework developed to improve the process for design and implementation of systems that improve the quality and efficiency of health care delivery, which in turn will improve outcomes.

In April 2007, CMS introduced a new national initiative, CMS-2010-0251, encouraging states to conduct assessments of their Medicaid business process model against the MITA Business Process Model. Medicaid technology investments include traditional claims processing systems, as well as eligibility systems. In 2009 CMS released version 2.01 of the MITA framework. The changes seen in version 2.01 were limited to the Business Architecture. Many of the business processes that were not defined in version 2.0 have been defined in version 2.01. Public Knowledge based this SS-A on version 2.01 of the MITA Framework.

MITA prescribes an enterprise architecture for Medicaid programs that is comprised of three architectural layers:

- **Business Architecture** – a layer that focuses on business processes and a maturity model that describes in detail how Medicaid operations are expected to mature over time
- **Information Architecture** – a layer that focuses on data and information to support the business architecture, including data management strategies and data standards
- **Technical Architecture** – a layer that focuses on the technology that supports both the information architecture and business capabilities, and defines a set of services and standards that states can use to plan and specify their future systems

The focus of this project is on the Business Architecture, which encompasses the SS-A. The Information and Technical Architectures have not yet been fully defined by CMS. Further definition of these architectures is expected in version 3.0 of the MITA Framework, scheduled for release in February of 2012.

MITA provides a standardized framework that allows the State to pay for the Medicaid program's upcoming system improvements and implementations with enhanced CMS funding. More than a "compliance" activity, MITA facilitates transformation of business processes, required data and information, and supportive technology of the Medicaid organization.

1.1.1 State Self-Assessment

The SS-A is a tool for states to plan their transitions from current capabilities to future, targeted capabilities. Using the SS-A, a state reviews its current operations and develops a list of target capabilities (transition goals) that allow it to meet its strategic goals. Target capabilities are those that the State plans to implement in order to transform its Medicaid enterprise to align with MITA principles. An SS-A, based on the MITA Framework, is now a prerequisite to secure enhanced federal funding for Medicaid program improvements. Specifically, Colorado Medicaid's Advance Planning Documents (APDs) now must include information on how a project is expected to improve program capabilities consistent with the MITA Framework.

CMS has requested that states attach an SS-A 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.

1.1.2 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 clients.

1.1.3 MITA Goals

The MITA Framework, process, and planning guidelines are designed to align technology planning with Medicaid business needs and objectives. The primary goals of MITA are:

- Seamless and integrated systems with effective communication.
- Common Medicaid goals through interoperability and shared standards.
- Promoting environments that are flexible, adaptable, and can rapidly respond to changes in programs and technology.
- Promotion of an enterprise view that supports enabling technologies aligned with Medicaid business processes and technologies.

- Providing timely, accurate, useable, and easily accessible data to support analysis and decision making for healthcare management and program administration.
- Providing performance measurement for accountability and planning.
- Coordinating with public health and other partners to integrate health outcomes within the Medicaid community.

1.2 MITA and What it Means to Colorado

Adoption of MITA starts by completing a MITA SS-A, where the State uses the components of the MITA Business Architecture (BA) to establish current capabilities and maturity levels and to choose future levels of maturity as the targets for improvement. States will provide CMS with a MITA Maturity Model Roadmap that addresses goals and objectives, key initiatives, and transition goals covering a 5-year outlook that anticipates the timing for reaching the anticipated MITA maturity, with annual updates.

CMS intends to apply seven conditions and standards to each Medicaid technology investment, and each request will be viewed in light of existing, interrelated assets and their level of maturity. These conditions and standards apply to grants and other federal initiatives, as well as enhancements mandated by a state's business needs.

The MMIS procurement will have a major impact on the Colorado Medicaid enterprise, by laying the groundwork for a future all-health-services enterprise, through participation with other State health agencies. Through the MITA transformation, Colorado Medicaid will use technology to improve service to the clients and providers who make up the Medicaid program.

The SS-A is used to support the planning and acquisition of the MMIS through the following tasks:

- Enable the identification of Requirements – The business processes within the SS-A are used as a building block for identifying implementation requirements.
- Support development of the APDs – CMS will ask states to attach their SS-As to their APDs. The SS-A 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.

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

- Evaluate Design, Development, and Implementation – The SS-A should be referred to during requirements validation, design, development, testing, and implementation.

- Support certification of the MMIS – 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.

This report assesses the Colorado Medicaid as-is environment, the to-be environment, and begins to address how Colorado Medicaid will get there, in part, through the MMIS procurement.

1.3 Aligning MITA Objectives with Department Strategic Objectives

In the MITA SS-A concept, CMS defines the first step of the SS-A process as identifying the State Medicaid goals and objectives. Public Knowledge has mapped the MITA objectives to the objectives defined in the Department's Five-Year Strategic Plan. The two sets of objectives are very closely aligned. Transition goals were validated with the Department in the "To Be"/Roadmap sessions that were facilitated by Public Knowledge. Implementation of these transition goals will advance the Department's MITA maturity level, allowing for the realization of both the MITA and Department defined objectives. Descriptions of objectives for the Department and MITA are detailed on the following page.

Department Objectives

- **Increase the Number of Insured Coloradans** – Increase the number of people who are eligible and enroll in public programs
- **Improve Health Outcomes** – Reduce inappropriate and avoidable utilization of services
- **Increase Access to Health Care** – Increase the number of providers serving clients enrolled in public programs
- **Contain Health Care Costs** – Payment policies and mechanisms will be tied to expected outcomes
- **Improve the Long-Term Care Service Delivery System** – Continuously identify and implement administrative efficiencies

MITA Objectives

The MITA goals translate into the following objectives:

- Adopt data and industry standards
- Promote reusable components; modularity
- Promote efficient and effective data sharing to meet stakeholder needs
- Provide a beneficiary-centric focus
- Support interoperability, integration, and an open architecture
- Promote secure data exchange (single entry point)
- Promote good practices (e.g., the Capability Maturity Model [CMM] and data warehouse)
- Support integration of clinical and administrative data
- Break down artificial boundaries between systems, geography, and funding (within the Title XIX Program)

The table on the following page demonstrates alignment between the Department's five-year strategic objectives and the MITA objectives[1]. The vision created from this analysis was used as a guide to help define Colorado's transitions goals for maturing its Medicaid enterprise.

[1] MITA Objectives defined in the MITA Framework 2.0, CMS 2006

Table 1 – Mapping of MITA Objectives to Department Strategic Objectives

MITA Objectives	Department Strategic Objectives				
	Increase the Number of Insured Coloradans	Improve Health Outcomes	Increase Access to Health Care	Contain Health Care Costs	Improve the Long-Term Care Service Delivery System
Adopt data and industry standards		✓	✓	✓	✓
Promote reusable components; modularity		✓	✓	✓	✓
Promote efficient and effective data sharing	✓	✓	✓	✓	✓
Provide a beneficiary -centric focus	✓	✓	✓	✓	✓
Support interoperability and integration and an open architecture	✓	✓	✓	✓	✓
Promote secure data exchange	✓	✓	✓	✓	✓
Promote good practices (e.g., data warehouse)	✓	✓	✓	✓	✓
Support integration of clinical and administrative data		✓		✓	✓
Break down boundaries between systems, geography, and funding	✓	✓	✓	✓	✓

1.4 Summary Of As Is Assessment Findings

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 defined 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/area in relation to the MITA Maturity Model. The following guidelines were considered in assigning the capability level for each State business process.

- It is expected that all states completing an SS-A 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 consistently available in implemented MMISs. 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.
- 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.
- The lowest business capability level assigned to a business process will dictate the overall maturity level for that particular business area.

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 SS-A. Transition goals, based on the "To Be" items identified, will help the State move closer to the projected level of business capability.

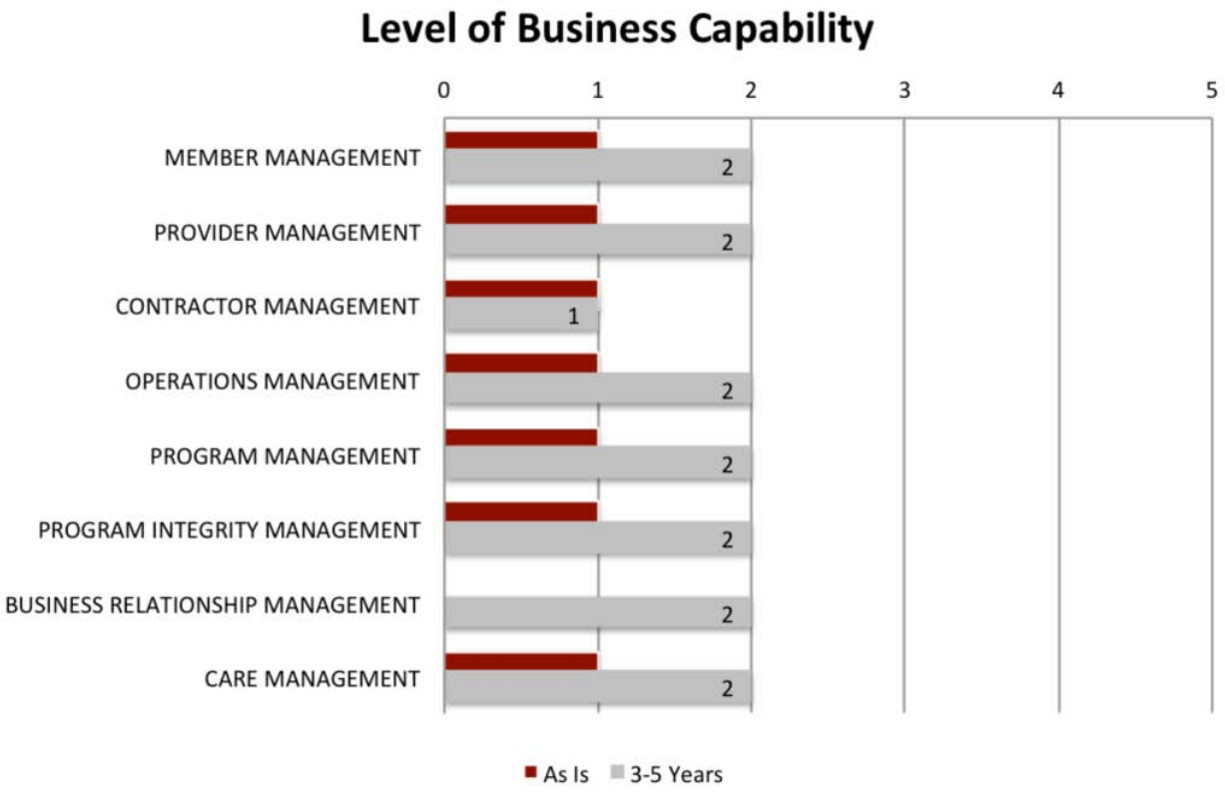


Figure 1 – *Level of Business Capability by Business Area*

Member Management – Current Level 1/Future Level 2

Outside of eligibility determination and client enrollment, the majority of Colorado's Member (Client) Management business processes are manual and lack coordination within the agency. These manual processes result in additional staff resource needs to manage the workload. Determine Eligibility and Member Enrollment are exceptions in that they are primarily automated and standardized processes. Eligibility is automatically provided to, and loaded into, the MMIS from a CBMS feed that includes foster care data from the TRAILS system. MMIS accepts the eligibility and automatically enrolls the client into the appropriate benefit package(s). There is no communication loop that supports reconciliation of eligibility data between the CBMS and MMIS. Information revised due to edits in the MMIS is not shared with the CBMS (and then to TRAILS), causing downstream data integrity issues that impact claims payment, client/applicant communication, and population outreach.

Transition goals such as standardize transactions, system flexibility, electronic client management, and the ability to support bi-directional interfaces will move most processes in this business area to a Level 2, and some to a Level 3, on the MITA Maturity model.

Provider Management – Current Level 1/Future Level 2

Colorado's Provider Management business processes are primarily manual and staff intensive. Currently, the State does not have automated business rules or an online provider application. Enrolling providers requires State staff to review and verify each application. The Manage Provider Grievance and Appeal process and Perform Provider Outreach process also rely on manual intervention. Provider billing manuals and related documentation are available through the provider services website; however, documents are developed and maintained manually, then uploaded to the website.

The State has a Web Portal to provide some automation and electronic information distribution. The Web Portal's self-service business processes are not currently available to all provider types; requiring State staff or Fiscal Agent staff to enter paper claims, capture provider information updates, and to respond to provider information inquiries for provider types that do not have Web Portal access. In addition to the Web Portal, Colorado Medicaid has an automated process for program communication, but continues to maintain paper communication methods as requested by some providers.

Transition goals such as electronic provider management, centralized access to data, system flexibility, and improved reporting capabilities will move most processes in this business area to a Level 3. The Manage Provider Grievance and Appeals and Perform Provider Outreach, especially to non-enrolled providers, are targeted at a Level 2 for the future capabilities. These processes will require more manual intervention than other processes in this business area.

Contractor Management – Current Level 1/Future Level 1

Colorado's Contractor Management business processes are manual and staff intensive but, in most cases, are well coordinated within the agency. The State uses the Bid Information Distribution System (BIDS) to electronically distribute solicitation opportunities and announce their award. Once a proposal is received via paper, disk, fax or email, State staff manually review, evaluate and, when appropriate, score proposals. All aspects of awarding

the contract, monitoring the contract, communicating with contractors, answering inquiries regarding contractors, performing outreach and closing out contracts are also manual processes. State Purchasing maintains a statewide Contract Management System that is used, depending on the contract type, to track and manage information related to the contracts. However, this data does not integrate with the MMIS to assist in electronically monitoring contract performance measures. For contracts that are not maintained in the Contract Management System, the Purchasing & Contracting Services Section maintains contract information in Department-specific databases. There is no central repository to track information and status related to contract grievances and appeals.

Providing centralized access to data and the ability to store electronic attachments are key transition goals impacting this business area. Some processes in this business area will mature to a Level 2, while others will remain at a Level 1. Awarding and closing out contracts, as well as producing RFPs, will remain highly manual processes in the next three to five years, keeping them at a Level 1 for future capabilities.

Operations Management – Current Level 1/Future Level 2

Colorado's Operations Management business processes, such as authorizing services, referrals, and treatment plans are highly manual, lack coordination, and are staff intensive. The pharmacy program has implemented a separate claims payment system that is able to take advantage of a number of processes to provide consistent results. The Prescription Drug Card System (PCDS) interfaces with MMIS, but not all drug related claim types are passed to the MMIS. Any reconciliation between the two systems requires manual review and intervention.

In general, Colorado's Operations Management business processes surrounding claims payment and adjudication are well coordinated and incorporate many automated processes. However, due to system configuration limitations and a large change request (CSR) backlog, the current MMIS does not include the most appropriate business rules and data validation requirements. Therefore, additional manual steps to review and edit claims have been created to support payment processing. Paper claim attachments used in the adjudication process are not centralized or easily accessible for State staff.

The Colorado Financial Reporting System (COFRS), implemented in 1991, is the statewide accounting system that interfaces with the MMIS for all payment processing. Due to the constraints of both legacy MMIS and COFRS systems, payment data provided to COFRS via an interface is limited and does not allow any opportunity to synchronize data in a way that keeps both systems accurate. As a result, State staff has implemented many manual processes to maintain and update necessary MMIS information used for fiscal analysis and reporting. State staff are also required to develop and produce multiple reports in order to manually reconcile payment data with claims data for reconciliation and auditing purposes.

Preparation of payment reporting is primarily automated, but there are many opportunities to streamline access to the information used to compile the reports. Information used to generate payment reports is not included in the DSS and requires State staff to run reports from multiple sources that may not contain information from the same point in time. Additional manual validation steps have been implemented to ensure accurate reporting.

Colorado's Third Party Liability (TPL) business processes include a combination of automated and manual processes. The MMIS receives a standard interface from CBMS, which has been designed to overwrite the eligibility data in the MMIS. This overwrite process creates a number of issues for MMIS business processes. For TPL specifically, this removes historical eligibility data and overwrites important information needed to support recoupment. Colorado's TPL and recovery identification opportunities are reliant on manual processes. The lack of historical eligibility data requires additional manual intervention. The involvement of a TPL contractor augments the process and has established an effective means of recovery; however, the current MMIS lacks a robust TPL tracking and validation that would allow the State staff to strengthen Colorado's cost avoidance capabilities.

Transition goals such as centralize access to data, the ability to support bi-directional interfaces, system flexibility, and electronic financial management, will drive a majority of the processes in this business area from a Level 1 to a Level 2. Many of the business processes related to payments will mature to a Level 3.

Program Management – Current Level 1/Future Level 2

Colorado's Program Management business processes are mainly manual, lack coordination within the agency and are staff intensive. Overall, the manual clearance process was consistently noted as a roadblock to quick implementation and approval of programs, policy, change requests, etc.

Colorado does not have a standardized process to coordinate and maintain historical program administration and historical policy decisions. Specifically, the MMIS focuses on payment/claims adjudication and does not have features or functionality that easily support program/policy staff decision tracking or impact inquiries. Information gathered for program evaluation, performance measurement, and federal reporting is decentralized making the manual process very time intensive. Additionally, Colorado's case management information is not integrated with eligibility information or claims information (Benefits Utilization System (BUS), MMIS, CBMS do not synchronize data) creating further reporting complications. Inconsistent data sources used to report performance measure findings result in information that lacks credibility with contractors.

A large concern for the State is the MMIS has a limited ability to track, report and handle multiple pricing structures for both Managed Care encounters and fee-for-service claims. This regularly creates conflicts when establishing new benefit packages and requires additional manual workarounds to enter appropriate data for claim/encounter adjudication.

Transition goals such as the ability to support bi-directional interfaces, improve reporting capabilities, centralize access to data, and system flexibility, will move most processes in this business area from a Level 1 to a Level 2. A small number of business processes, especially related to Pharmacy and financial reporting, will mature to a Level 3.

Program Integrity Management – Current Level 1/Future Level 2

Colorado's Program Integrity business processes are very manual and time intensive. Cases are identified by referral, client Explanation of Medical Benefit (EOMB) responses, or through manual development of reports that target data groups or patterns. Once a case has been established, additional data is manually gathered and analyzed to determine what actions will be necessary. Processes related to coordination of required course of action;

including communication with the provider, money recovery and applying monies appropriately are all manual.

Program Integrity, a small business area with only two business processes, will be impacted by a number of the transition goals. One of the processes is targeted to mature to a Level 2, and the other to a Level 3.

Business Relationship Management – Current Level 1/Future Level 2

Colorado's Business Relationship Management business processes are mainly manual. However, the process of implementing the agreements with other agencies, contractors and providers is largely standardized and coordinated within the agency. Currently, the State does not maintain a central and secure location to manage the exchange of data.

This business area will benefit from standardized processes, an automated Clearance process, standardized transactions, and system flexibility. Three of the four processes in this business area are targeted to mature to a Level 2, with the remaining process maturing to a Level 3.

Care Management – Current Level 1/Future Level 2

Colorado's processes around Care Management are highly manual, lack coordination within the agency and are staff intensive. Discussions around care management indicate that staffing levels are too low to manage the workload. There is no interface between MMIS, CBMS and the Long Term Care Case Management system, called the Benefits Utilization System (BUS), requiring staff to review multiple systems to determine the appropriate and accurate level of care for clients. In addition, SME felt that the lack of standardization, combined with the complexity of reviewing data in multiple systems to assess appropriate services, occasionally leads to over-authorization of services.

Transition goals such as the ability to support bi-directional interfaces, centralize access to data, and improve reporting capabilities will move three of the four processes in this business area to a Level 3 and the remaining process to a Level 2 on the MITA Maturity Model.

Managed Care – Current Level 1/Future Level 2

Colorado's Medicaid Managed Care documentation covers applicable business processes from each MITA business area, as they apply specifically to the Managed Care program.

Managed Care was treated as a separate business area due to the distinct differences between Managed Care processes and the fee-for-service business processes, which also differ in their business capability levels. This section addresses findings and MMIS impacts when the process differs from the fee-for-service program.

Findings related to Colorado's Managed Care business processes are largely the same for: Contractor Management, Member (Client) Management, Business Relationship Management business areas.

Currently, the MMIS does not completely support the needs of the Managed Care encounters, causing a large number of workarounds. While some Managed Care business processes are automated, there are several manual processes that are not present for many of the fee-for-service business processes. Currently, CHP+ claims processing and adjudication is performed by an ASO and the encounter information is not included within the MMIS.

Centralizing access to data, automating workflow management, the ability to support bi-directional interfaces, and an audit trail and access to history are some of the key transition goals that will move most Managed Care business process to a Level 2 on the MITA Maturity Model.

Section 2 – Business Architecture SS-A For Medicaid

2.1 SS-A Assessment Approach and Methodology

Between October 2011 and January 2012, Public Knowledge (PK) worked with the Department to identify subject matter experts (SMEs) at the Department and other State Agencies who could describe current and future Colorado MMIS capabilities. The series of "As Is" and "To Be" interviews engaged 99 SMEs throughout the Department and other State agencies, including Division Directors, Deputy Directors, other managers and front-line experts with extensive knowledge of the Colorado Medicaid program. A summary of the participants by division is provided in Appendix C of this document.

We applied a methodology that associated the MITA model to the Colorado Medicaid program, in order to create an accurate and complete picture of the Colorado Medicaid program. We worked with the Department and other agency SMEs to document current processes and validate future capability states. We validated these preliminary views with the Department SMEs to achieve an assessment of each business process within Colorado Medicaid.

The MITA SS-A process included multiple phases and checkpoints to make sure that processes were completely and thoroughly reviewed. All parties involved in the SS-A were apprised of project goals, timelines, progress, and assessment output. The project benefitted from Department executive sponsorship and oversight.

The assessment methodology is presented in the following figure with the iterative steps described further in Figure 2 on the following page:

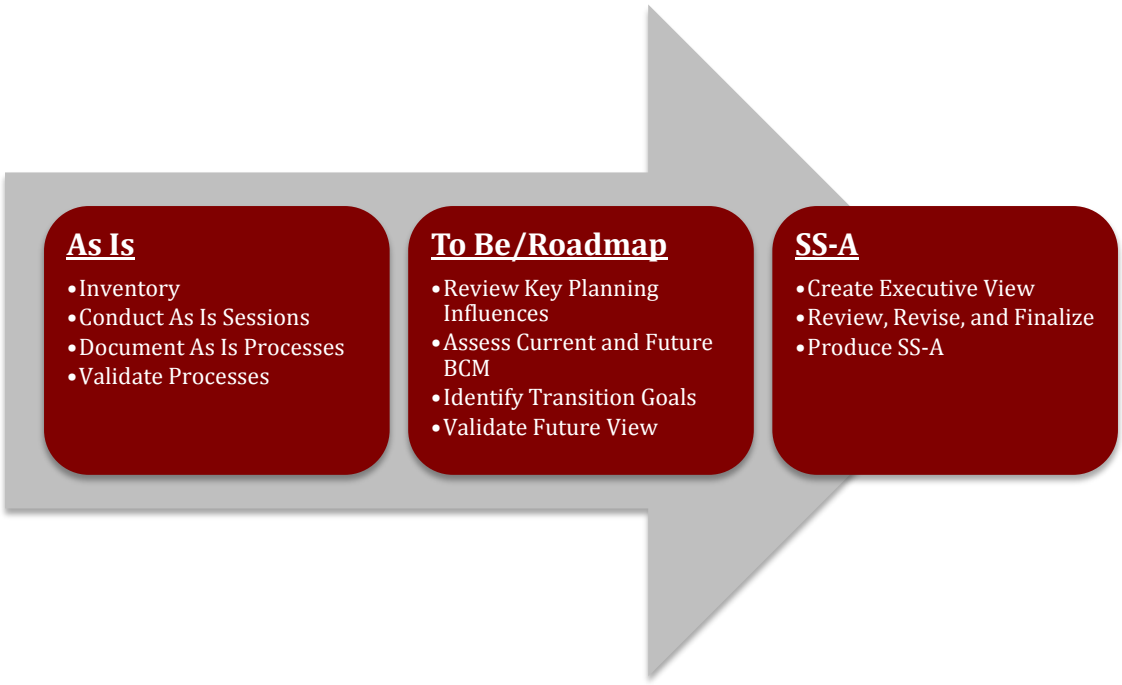


Figure 2 – *Colorado MITA SS-A Methodology*

Set up and inventory – PK and the Department worked together to create an inventory of Colorado Medicaid business processes and their related SMEs for participation in the MITA "As Is" sessions. The "As Is" sessions were scheduled and invitations to the meetings were delivered by the Department.

Conduct MITA "As Is" Sessions – Using Department SMEs, current Colorado Medicaid business processes were documented based on the MITA Framework, in a use case format.

Validate "As Is" business processes – The "As Is" business processes were then validated by Colorado Medicaid SMEs to affirm an accurate assessment. Department comments were incorporated and all processes were compiled into a comprehensive report, organized by business area. This final consolidation resulted in the final assessment of 72 Colorado Medicaid business processes.

Reference key planning influences – PK reviewed existing strategic plan materials, including existing or in-process strategic planning efforts for the evolving Colorado Medicaid organization, as well as other relevant planning documents. PK also inventoried and reviewed current federal and state initiatives impacting the Colorado Medicaid program.

Assess current and future business capabilities – PK used the "As Is" documentation, along with agency goals, objectives, and initiatives, to assess the current and future MITA business capability levels for Colorado Medicaid. Three to five-year transition goals for the targeted business capabilities for all Colorado Medicaid business processes were identified.

Validate 'future' views – PK engaged the Department business units and other stakeholders in a review of the current and future view of business capabilities for Colorado Medicaid processes to validate our assessments.

Create executive view – Using the validated assessment information, we distilled and presented an Executive Summary that provided an "at-a-glance" view of Colorado Medicaid's current and future states, including an overview of MITA and implications for the Colorado Medicaid program.

Produce SS-A – The final deliverable is an integrated product that includes the Executive Summary, the current and future views, and an analysis of the data collected during the assessment. All data collected was reviewed, revised, and finalized as needed.

2.2 Mapping of MITA to Colorado Medicaid Business Processes

Public Knowledge mapped the Colorado Medicaid program's business areas and processes to the business areas and processes in the MITA Framework Business Process Model. In some cases, the State's vocabulary differs from the MITA vocabulary. There are cases where Colorado Medicaid has a business process that is not represented in the MITA Business Process Model. These processes have been included in the mapping below, as well as the Business Capability Matrix in Appendix B. CMS will use this information to improve the MITA Framework in future versions.

Table 2 – Mapping of MITA Business Processes to Colorado Medicaid Business Processes

MITA Business Area	State Business Area	MITA Business Process	State Business Process
Member Management	Eligibility Division	ME Determine Eligibility	Determine Client Eligibility
		ME Enroll Member	Enroll Medicaid Client
			Enroll CHP+ Client
		ME Disenroll Member	Disenroll Member
		ME Inquire Member Eligibility	Inquire Client Eligibility
		ME Manage Member Information	Manage Client Information
		ME Perform Population and Member Outreach	Perform Client Outreach
		ME Manage Applicant and Member Communication	Manage Applicant and Client Relations
		ME Manage Member Grievance and Appeal	Manage Client Appeal
Provider Management	Provider Services	PM Enroll Provider	Enroll Provider
		PM Disenroll Provider	Disenroll Provider
		PM Manage Provider Information	Manage Provider Information
		PM Inquire Provider Information	Inquire Provider Information
		PM Manage Provider Communication	Manage Provider Relations
		PM Manager Provider Grievance and	Manage Provider Grievance and Appeal

MITA Business Area	State Business Area	MITA Business Process	State Business Process
		Appeal	
		PM Perform Provider Outreach	Perform Provider Outreach
Contractor Management	Contract Administration	CM Award Health Services/Administrative Contract	Award Contract
		CM Manage Health Services/Administrative Contract	Monitor Contract
		CM Close-out Health Services/Administrative Contract	Close-out Contract
		CM Manage Contractor Information	Modify Contract
		CM Perform Potential Contractor Outreach	Perform Potential Contractor Outreach
		CM Manage Contractor Communication	Contractor Communication
		CM Support Contractor Grievance and Appeal	Contractor Protest
Operations Management	Agency Administration and Operations	OM1 Authorize Referral	Prior Authorization
		OM1 Authorize Service	Prior Authorization
		OM1 Authorize Treatment Plan	Define Benefit Packages
		OM2 Apply Claim Attachment	Apply Claim Attachment
		OM2 Apply Mass Adjustment	Apply Mass Adjustment
		OM2 Audit Claim/Encounter	Audit Claim/Encounter
		OM2 Edit Claim/Encounter	Edit Claim/Encounter
		OM2 Price Claim/Value Encounter	Price Claim
		OM3 Prepare COB	N/A
		OM3 Prepare EOB	Prepare EOMB
		OM3 Prepare HCBS Payment	Prepare HCBS Payment
		OM3 Prepare Premium EFT/Check	Prepare Premium EFT/Check
		OM3 Prepare Provider EFT/Check	Prepare Provider EFT
		OM3 Prepare Remittance Advice/Encounter Report	Prepare Remittance Advice/Encounter Report

MITA Business Area	State Business Area	MITA Business Process	State Business Process
		OM4 Prepare Capitation Premium Payment	Prepare Capitation Premium Payment
		OM4 Prepare Health Insurance Premium Payment	Prepare HIBI Payment
		OM4 Prepare Medicare Premium Payment	Medicare Buy-in Process
		OM5 Inquire Payment Status	Inquire Payment Status
		OM5 Manage Payment Information	Manage Changes & Reconcile Capitated Payment Information
		OM6 Calculate Spend-Down Amount	N/A
		OM6 Prepare Member Premium Invoice	Prepare CHP+ Client Premium Invoice
		OM7 Manage Drug Rebate	Drug Rebate
		OM7 Manage Estate Recovery	Estate Recovery
		OM7 Manage Recoupment	Overpayment Recovery
		OM7 Manage Settlement	Manage Hospital Cost Report Settlement
		OM7 Manage TPL Recovery	Manage TPL Recovery
Program Management	Program/Policy Management	PG1 Designate Approved Service/Drug Formulary	Designate Approved Service Formulary
			Designate Approved Drug Formulary
		PG1 Manage Rate Setting	Manage Rate Setting
		PG1 Develop and Maintain Benefit Package	Develop and Maintain Benefit Package
		PG2 Develop and Maintain Program Policy	Develop and Maintain Program Policy
		PG2 Maintain State Plan	Maintain State Plan
		PG2 Develop Agency Goals and Initiatives	TBD
	Agency Administration and Operations	PG3 Manage Federal Financial Participation for MMIS	Manage FFP
		PG3 Formulate Budget	Manage Budget

MITA Business Area	State Business Area	MITA Business Process	State Business Process
		PG3 Manage State Funds	Manage State Funds
		PG3 Draw and Report Federal Funding Participation	CMS Reporting
		PG3 Manage F-MAP	Manage F-MAP
		PG4 Manage 1099s	Manage 1099s
		PG4 Perform Accounting Functions	Accounting
	Program/Policy Management	PG5 Develop and Manage Performance Measures and Reporting	Develop and Manage Performance Measures and Reporting
		PG5 Monitor Performance and Business Activity	Monitor Performance and Business Activity
		PG6 Manage Program Information	Manage Program Information
		PG6 Maintain Benefit/Reference Information	Maintain Reference Data
		PG6 Generate Financial and Program Analysis/Report	Generate Reports
Business Relationship Management	Contract Administration	BR Establish Business Relationship	Establish Data Use Agreements
		BR Manage Business Relationship	Manage Data Use Agreements
		BR Manage Business Relationship Communication	TBD
		BR Terminate Business Relationship	Terminate Data Use Agreements
Program Integrity Management	Program Integrity	PI Identify Candidate Case	Identify Candidate Case
		PI Manage Case	Manage Case
Care Management	Contract Administration	CM Establish Case	Establish Case
		CM Manage Case	Case Management
		CM Manage Medicaid Population Health	Medicaid Population Health Outreach
		CM Manage Registry	Manage Immunization Registry

2.3 Colorado Medicaid Current Change Initiatives

During the "To Be"/Roadmap sessions, Public Knowledge compiled a list of federal and state initiatives that currently influence the Medicaid enterprise. Many of these initiatives fundamentally impact Departmental business processes and information systems (including: MMIS, DSS, CBMS, and others). These initiatives, along with Department goals and objectives, drive the transition goals defined in the "To Be" Roadmap in Section 3. Successful implementation of these initiatives requires not only the consideration of current technology, but in many cases, reconsideration and enhancement of current business processes which will ultimately lead to a more mature Medicaid enterprise for the State.

The Patient Protection and Affordable Care Act (ACA) will increase the number of Coloradans that are eligible for Medicaid assistance. ACA also promotes administrative simplification of the enrollment process and form, promotes increased communication regarding available benefits, and promotes solutions to improve access to care and quality of care. Additionally, a key component of the ACA requires that states implement a Health Insurance Exchange (HIX) to facilitate the expanded access to Medicaid assistance. Increasing the number of eligible clients also increases the transactional support required of the Department and its systems. In order to adjust, the Department will reevaluate and redesign its business processes, as well as the systems used to support the business processes it performs.

The American Recovery and Reinvestment Act (ARRA) offers enhanced federal funding, including development and implementations of programs and systems that assist in maturing the State's Medicaid programs. Additionally, the ARRA supports states in developing systems that support Health Information Technology (HIT) and Health Information Exchanges (HIE). The goal of the HIT initiative is to encourage standardization of data and the exchange of data in the form of electronic health records. Specifically, the ARRA provides 100% funding for HIT initiatives that support improved quality, care coordination, and reductions in medical errors and duplicative care. Electronic health records also support many of the Departmental goals and objectives, including improving health outcomes and containing health care costs.

In many cases, system requirements defined in these initiatives cannot be supported by the Department's current legacy technology. Therefore, additional initiatives have been created to adopt new systems that enable the Colorado Medicaid enterprise to mature. Specifically, the MMIS procurement offers the Department the opportunity to enhance their technology capabilities and shift business capability focus from one that is manual and staff intensive, to one that is more strategic and reacts quickly to changes in legislation and process improvement opportunities.

Appendix F lists federal and State initiatives gathered during the "To Be"/Roadmap sessions. This list is not intended to be comprehensive, but rather it is used to demonstrate activities that reinforce the evolution of Colorado's Medicaid enterprise.

2.4 Business Architecture Assessment Results

The results of the Business Architecture Assessment, which includes the "As Is" and "To Be" assessment for each MITA business process, are detailed in Appendix B of this document.

The following table provides definition of the information that is captured in each of the six columns in the CMS version of the Business Architecture Assessment. The Business Architecture Assessment template was provided in the CMS MITA Framework version 2.0.

Table 3 **– Description of the MITA Business Architecture Assessment Table Columns**

Name	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.

Name	Description
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 business capability levels are described in the MITA Framework 2.01 as follows:

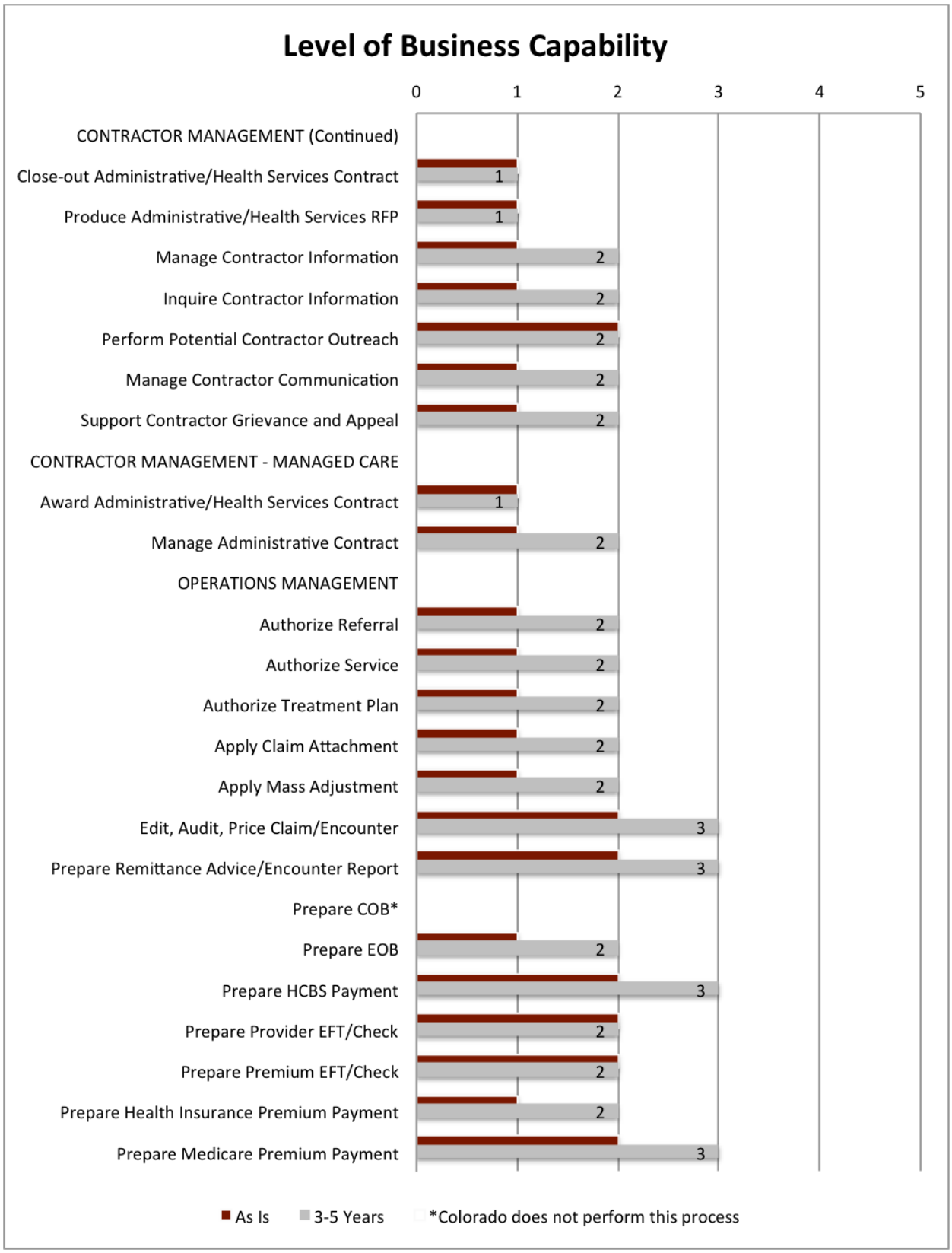
- **Level 1** – mostly manual, uncoordinated, staff intensive
- **Level 2** – moving to more electronic, more coordination within the agency, less staff intensive
- **Level 3** – using MITA standard interfaces (these interfaces have not been defined yet), increased coordination with other state agencies
- **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

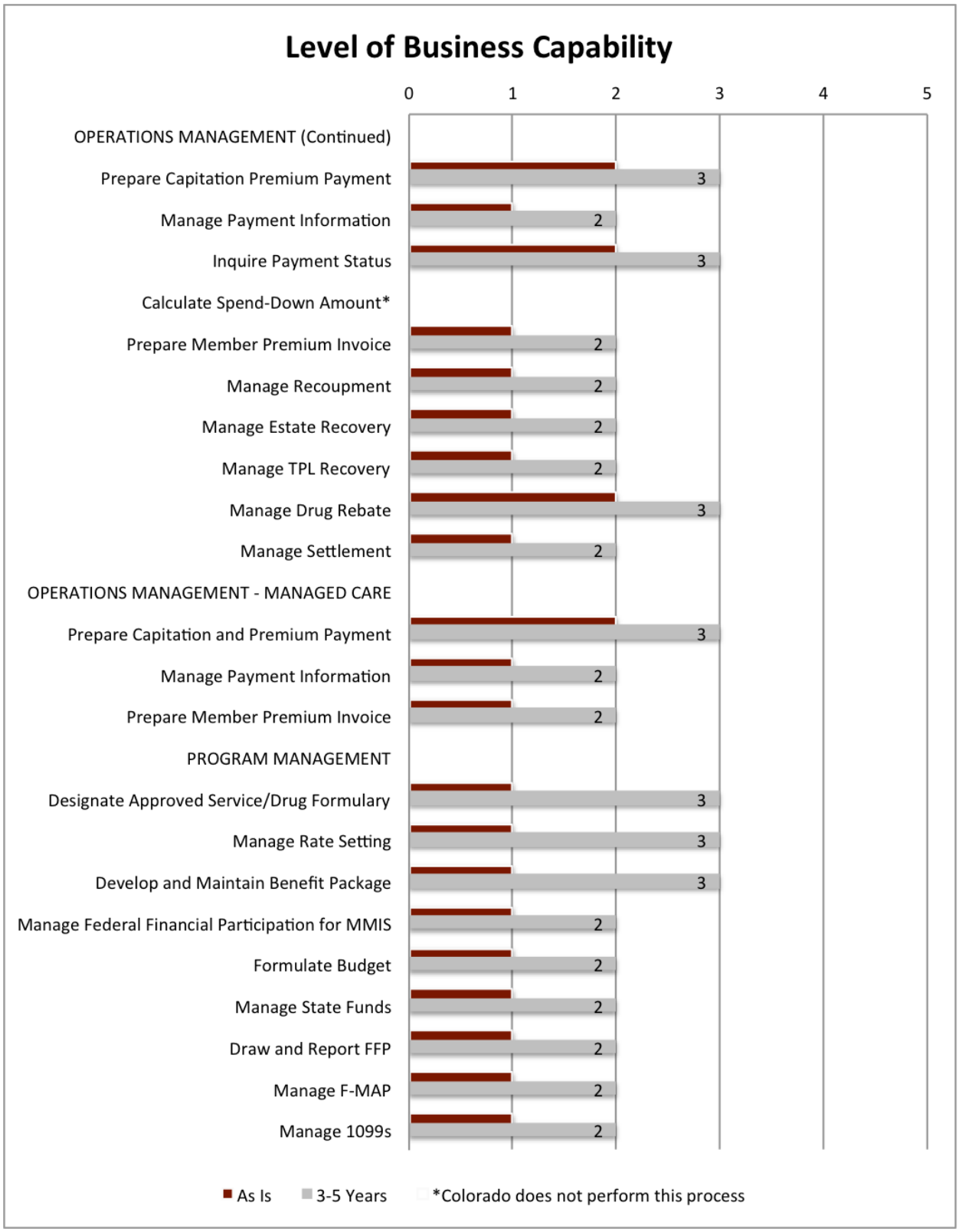
The levels are intended to communicate the capability of the business process/area in relation to the MITA Maturity Model. The following guidelines were considered in assigning the capability level for each State business process.

- It is expected that all states completing an SS-A 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 consistently available in implemented MMISs. 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.
- 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.
- The lowest business capability level assigned to a business process will dictate the overall maturity level for that particular business area.

Following is a graphic representation of the MITA business areas, their associated processes, and the projected movement for each over the next three to five years. There are a number of initiatives, including State goals and objectives, which are contributing to this movement along the MITA Maturity Levels. A comprehensive list of federal and State initiatives impacting the Colorado Medicaid program is included in Appendix F of this document.


Level of Business Capability
0
1
2
3
4
5
MEMBER MANAGEMENT
Determine Eligibility
3
Enroll Member
2
Disenroll Member
3
Inquire Member Eligibility
3
Manage Member Information
2
Perform Population and Member Outreach
2
Manage Applicant and Member Communication
2
Manage Member Grievance and Appeal
2
MEMBER MANAGEMENT - MANAGED CARE
Determine Eligibility
3
Enroll Member
3
Disenroll Member
2
PROVIDER MANAGEMENT
Enroll Provider
3
Disenroll Provider
3
Manage Provider Information
3
Inquire Provider Information
3
Manage Provider Communication
3
Manager Provider Grievance and Appeal
2
Perform Provider Outreach
2
PROVIDER MANAGEMENT - MANAGED CARE
Enroll Provider
2
CONTRACTOR MANAGEMENT
Manage Administrative/Health Services Contract
3
Award Administrative/Health Services Contract
1
As Is
3-5 Years
*Colorado does not perform this process


Level of Business Capability
0
1
2
3
4
5
CONTRACTOR MANAGEMENT (Continued)
Close-out Administrative/Health Services Contract
Produce Administrative/Health Services RFP
Manage Contractor Information
Inquire Contractor Information
Perform Potential Contractor Outreach
Manage Contractor Communication
Support Contractor Grievance and Appeal
CONTRACTOR MANAGEMENT - MANAGED CARE
Award Administrative/Health Services Contract
Manage Administrative Contract
OPERATIONS MANAGEMENT
Authorize Referral
Authorize Service
Authorize Treatment Plan
Apply Claim Attachment
Apply Mass Adjustment
Edit, Audit, Price Claim/Encounter
Prepare Remittance Advice/Encounter Report
Prepare COB*
Prepare EOB
Prepare HCBS Payment
Prepare Provider EFT/Check
Prepare Premium EFT/Check
Prepare Health Insurance Premium Payment
Prepare Medicare Premium Payment
As Is
3-5 Years
*Colorado does not perform this process


Level of Business Capability
0
1
2
3
4
5
OPERATIONS MANAGEMENT (Continued)
Prepare Capitation Premium Payment
3
Manage Payment Information
2
Inquire Payment Status
3
Calculate Spend-Down Amount*
Prepare Member Premium Invoice
2
Manage Recoupment
2
Manage Estate Recovery
2
Manage TPL Recovery
2
Manage Drug Rebate
3
Manage Settlement
2
OPERATIONS MANAGEMENT - MANAGED CARE
Prepare Capitation and Premium Payment
3
Manage Payment Information
2
Prepare Member Premium Invoice
2
PROGRAM MANAGEMENT
Designate Approved Service/Drug Formulary
3
Manage Rate Setting
3
Develop and Maintain Benefit Package
3
Manage Federal Financial Participation for MMIS
2
Formulate Budget
2
Manage State Funds
2
Draw and Report FFP
2
Manage F-MAP
2
Manage 1099s
2
As Is
3-5 Years
*Colorado does not perform this process

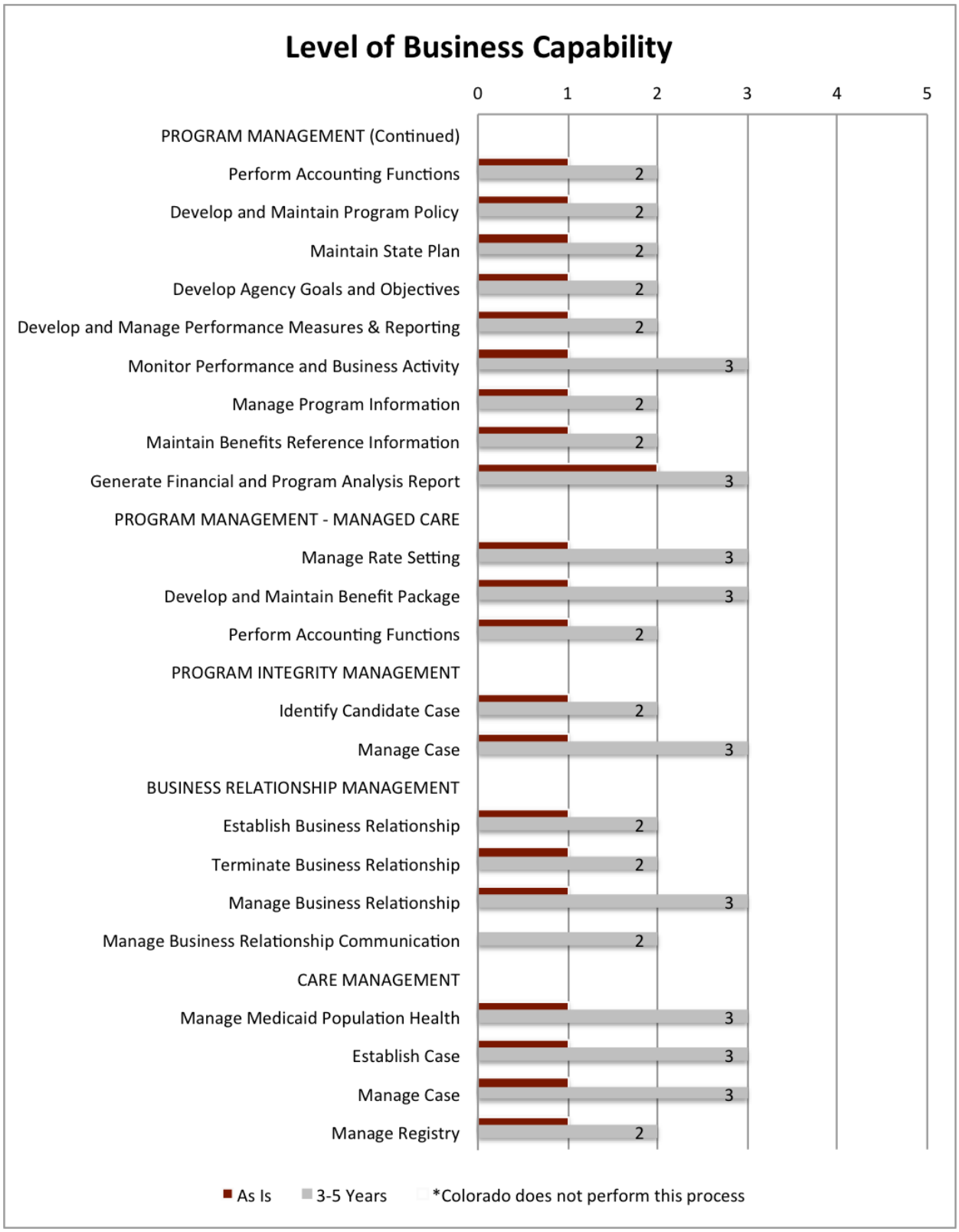


Figure 3 – *Colorado Medicaid Current and Future Business Capability*

Section 3 – Business Area Results

Public Knowledge worked with the Department to identify and validate Transition Goals, which are the foundation of the MITA Roadmap. These goals are a result of common themes that were identified in the MITA "As Is" and "To Be"/Roadmap sessions. They are needs and desires of Department staff that will move the organization from its current state of MITA maturity to an improved state for conducting business. The functionality described in the transition goals will improve the way the MMIS supports the Department's healthcare programs including Medicaid, CHP+, Managed Care, and Long-Term Care. Key components that should be considered in procurement of an MMIS include a workflow management application, enhanced web portal, and a configurable MMIS.

The MITA Roadmap outlines a plan for Colorado to transition from their current business capability level to the "To Be" capability level through the achievement of identified transition goals. The adoption of the architectures included in the MITA can be overwhelming to a state organization. The Roadmap communicates how the Department can adopt the precepts of MITA as they plan and implement initiatives. These initiatives may originate at the State level or be driven by federal legislation and guidance. As the Department evaluates initiatives it will be clear how to leverage the business capabilities matrices from the MITA to identify business and system requirements that will move Colorado along the continuum of the maturity model.

We have identified 24 transition goals related to the MITA Business Areas. Transition goals are a consolidated view of the "To Be" items identified for each of the business areas/processes. A listing of "To Be" items by business process can be found in the use cases in Appendix C. The transition goals are the roadmap for the Department. They describe how the Colorado Medicaid program will transition to their desired MITA maturity level over the next three to five years. The transition goals are listed and defined below. In the subsequent sections of the SS-A, the transition goals have been mapped to the applicable business processes.

Table 4 – Colorado Medicaid Transition Goals

Transition Goals
Ability to accept and store electronic attachments
Ability to create policy and utilization modeling and forecasting
Ability to support bi-directional interfaces
Audit trail and access to history
Automate Clearance process
Automate reconciliation process
Automate workflow management
Centralize access to data
Electronic Client Management
Electronic Financial Management
Electronic Provider Management
Electronic tracking of audit actions
Electronic tracking of performance measures
Electronic utilization tracking and forecasting
Improve, standardize, and automate electronic communication capabilities
Improve electronic Care Management
Improve electronic Contractor Management
Improve internal knowledge management process
Improve reporting capabilities
Increase staffing
Reduce lag between determination and posting data to MMIS
Standardize processes
Standardize transactions
System flexibility

Following are detailed definitions for each of the transition goals, which describe how the goals will advance the MITA Maturity Level for Colorado Medicaid:

Ability to accept and store electronic attachments. The Department expects that the new MMIS will support the ability to accept and store attachments submitted electronically. Attachments can include claim attachments, client documentation that may be produced by a

different system (e.g. notices), and provider documentation. Attachments would be indexed with the appropriate claim, client, and provider for retrieval as needed.

Ability to create policy and utilization modeling and forecasting. The Department expects that a separate environment mirroring the production environment of the MMIS could be used to support "what if" scenario modeling. The environment will also be separate from the test environment used to validate changes made to the system will perform as designed. The Department staff would be able to determine the impact of a policy or other change (e.g. change in payment methodology) on outcomes. The environment can also be used to forecast changes in utilization and payments.

Ability to support bi-directional interfaces. The Department desires interfaces to support passing information between systems where appropriate. One example is a bi-directional interface between the MMIS and CBMS to support the correction of errors identified when loading eligibility data into the MMIS. A bi-directional interface would allow the MMIS to pass back information to support updates to the CBMS system so that both systems are in sync with respect to client eligibility. A bi-directional interface will be necessary to develop an automated process for reconciliation between CBMS and the MMIS.

Audit trail and access to history. The Department desires a new MMIS that supports an online, human-readable audit trail. Access to changes to data within the MMIS allows the Department to understand the history of data changes on a record. The online, human-readable audit trail could identify the effective and termination date for the data; identify who made the changes (e.g. individual or automated process); and the value of the data element for the identified data range.

Automate Clearance process. The Department currently has many documents and forms that must be routed to applicable stakeholders for review and approval, i.e. Clearance. This process is currently a completely manual process, where the Clearance documents are manually delivered to each individual stakeholder. The Department desires a process where these Clearance documents can be automatically routed to the appropriate stakeholders.

Automate reconciliation process. The Department desires the ability to synchronize data between the MMIS and Colorado Financial Reporting System (COFRS). This will allow for

automated reconciliation of payment data with claims data for reporting and auditing purposes.

Automate workflow management. The Department desires to automate processes, where possible. There are automated solutions that support the establishment of work queues allowing in process documents to flow from one worker's queue to another.

Centralize access to data. The Department desires the ability to access real-time data for clients, providers, and benefit plan(s) for many programs including Foster Care, Medicaid, CHP+ and Long-Term Care. Access should be controlled to allow staff to have appropriate access to data to support their responsibilities. The State has several initiatives that may provide the tools to support achievement of this transition goal.

Electronic client management. The Department desires to move to electronic solutions to improve its ability to manage client information and client related processes. This transition goal includes the creation of an online, electronic client application through a State web portal. The data from the application would flow through to the appropriate systems to support determination of eligibility as well as benefit plan assignment. This goal also addresses a desire the move to electronic notifications to clients.

Electronic financial management. The Department desires to improve financial management processes by moving to more electronic processing. The Department wants to leverage information available electronically to support more efficient budgeting and financial forecasting. Electronic Financial Management will leverage solutions used to support centralized data access and policy/utilization modeling. The Department also desires to move to an improved payment system solution that can better support Medicaid and related programs in processing payments and other financial transactions.

Electronic provider management. The Department desires the implementation of an online, electronic provider enrollment application. The application would collect required information to support a decision for the provider to supply Medicaid or other programs' services. The online application would allow the attachment of supporting documentation to allow efficient decision-making. The solution would leverage an automated workflow so data and documentation could be routed to appropriate units responsible for decisions on

provider enrollment applications. In addition, providers could use an online portal to submit updates to their information; for example address changes or updated licensing information.

Electronic tracking of audit actions. The Department desires a solution that supports electronic capture and tracking of claims and provider audits. The Department plans to use this information to improve resolution of audit findings, and efficiency of the audit process.

Electronic tracking of performance measures. The Department desires a solution that supports the capture and tracking over time of specific performance measures. The Department plans to use this information to improve management of contracts with entities that provide services such as a MMIS Fiscal Agent.

Electronic utilization tracking and forecasting. The Department desires to track utilization trends to support improved decision-making on where to allocate program resources. The information collected and tracked over time will support forecasting allowing the Department to make more timely changes to policy and resources to improve healthcare and financial outcomes. This goal will leverage solutions used to achieve centralized data access and policy/utilization modeling transition goals.

Improve, standardize, and automate electronic communication capabilities. The Department desires to improve and standardize communications with clients, providers, and other agencies. The standardization of communications would allow the Department to move to electronic options for communications including a web portal and electronic messaging. In addition, standardization should support the ability to provide messaging in multi-language and multi-literate formats. These capabilities may result in timely communications that would lead to improved outcomes.

Improve electronic care management. The Department desires the improvement of their current Benefits Utilization System (BUS), or implementation of a new online, electronic case management system. Case managers will use the system to build and maintain treatment plans, and the system will interface with MMIS to verify appropriate benefit coverage. The solution would leverage an automated workflow so data and documentation could be routed to appropriate units responsible for decisions on case management activities.

In addition, case manages could access benefit and eligibility information provided in the MMIS and CBMS.

Improve electronic contractor management. The Department desires an electronic solution that supports automation of processes related to contractor management. Contractors include those entities that provide services to the Department or to clients and providers on behalf of the Department. Leveraging a solution that supports the tracking of performance measures is only one aspect. The solution should also provide the information necessary for the Department to accurately process payments to contractors.

Improve internal knowledge management process. The Department would like to improve communication and coordination intra-agency, as well as with external agencies. Increasing standardization of communication methods would allow better coordination across agencies that own a portion of certain processes. Creating access to appropriate information will enhance the Department's ability to make informed decisions. This will be both a technological and cultural shift for the Department, e.g. dissemination of information regarding State Plan Amendments, policy changes, or system enhancements.

Improve reporting capabilities. The Department desires a solution that provides robust reporting options. The solution would leverage the solution used to provide centralized access to data to improve reporting results. The Department expects that a solution would provide flexible reporting tools that provide a variety of graphical and data formats. The variety of formats would allow the Department to communicate data in a view appropriate for each audience. The solution would also provide options to automate reporting, including the ability of users to designate reports for generation at specific intervals, and the ability to set parameters for ad hoc reports. This also includes the ability to search on user defined data elements.

Increase staffing. Some areas of the Colorado Medicaid program have indicated that they desire increased staffing in order to become more efficient. Automation will help in some program areas, but others, such as policy and contract administration, will continue to have manual operations, and will require increased staff to improve efficiencies.

Reduce lag between determination and posting data to MMIS. The Department desires solutions that support more timely movement of eligibility data between the CBMS and MMIS. Reduction in the time to move data from CBMS to the MMIS will result in more timely care to clients. In addition, the data would need to be available sooner to systems receiving this data from the MMIS including the PDCS.

Standardize processes. The Department desires to standardize processes to support more efficient results. Standardized processes result in more predictable decisions removing, where appropriate, the subjectivity in decision-making. Standardization would allow better coordination across agencies that own a portion of certain processes. Examples of processes that could be standardized are the grievance and appeals process and the contracting process.

Standardize transactions. The Department desires to increase the use of standard transactions including national electronic transactions' standards. The Department would like to take advantage of enhanced validation available for standard electronic transactions to improve efficiency in the processing of transactions. Improved validation means transactions will be rejected for missing required information prior to processing, reducing the amount of transactions that have to be processed through the MMIS.

System flexibility. The Department desires an automated solution that is easily and quickly configurable based on changing business requirements. The system would focus on configuration changes rather than custom coding of business requirements. The system vendor will need to be intimately familiar with its solution in order to make recommendations to best incorporate business requirement changes. This goal may also require an evaluation of the process to communicate the Department's requirements for a change. Making this process more efficient in achieving Department approval for changes will reduce the amount of time to get business requirements implemented in the system and increase accuracy of system transactions. Examples include the ability to make payments through benefit plans/services created or the ability to add new data fields to the system that can drive workflow and/or reporting capabilities.

3.1 Member (Client) Management

3.1.1 Description

The Member (Client) Management business area is a collection of business processes involved in determining eligibility, communications between the Medicaid agency and the prospective or enrolled client, and actions that the agency takes on behalf of the client. These processes share a common set of client-related data. The goal for this business area is to improve healthcare outcomes and raise the level of consumer satisfaction. The following graphic depicts the structure of the Member (Client) Management business area and the associated business processes.

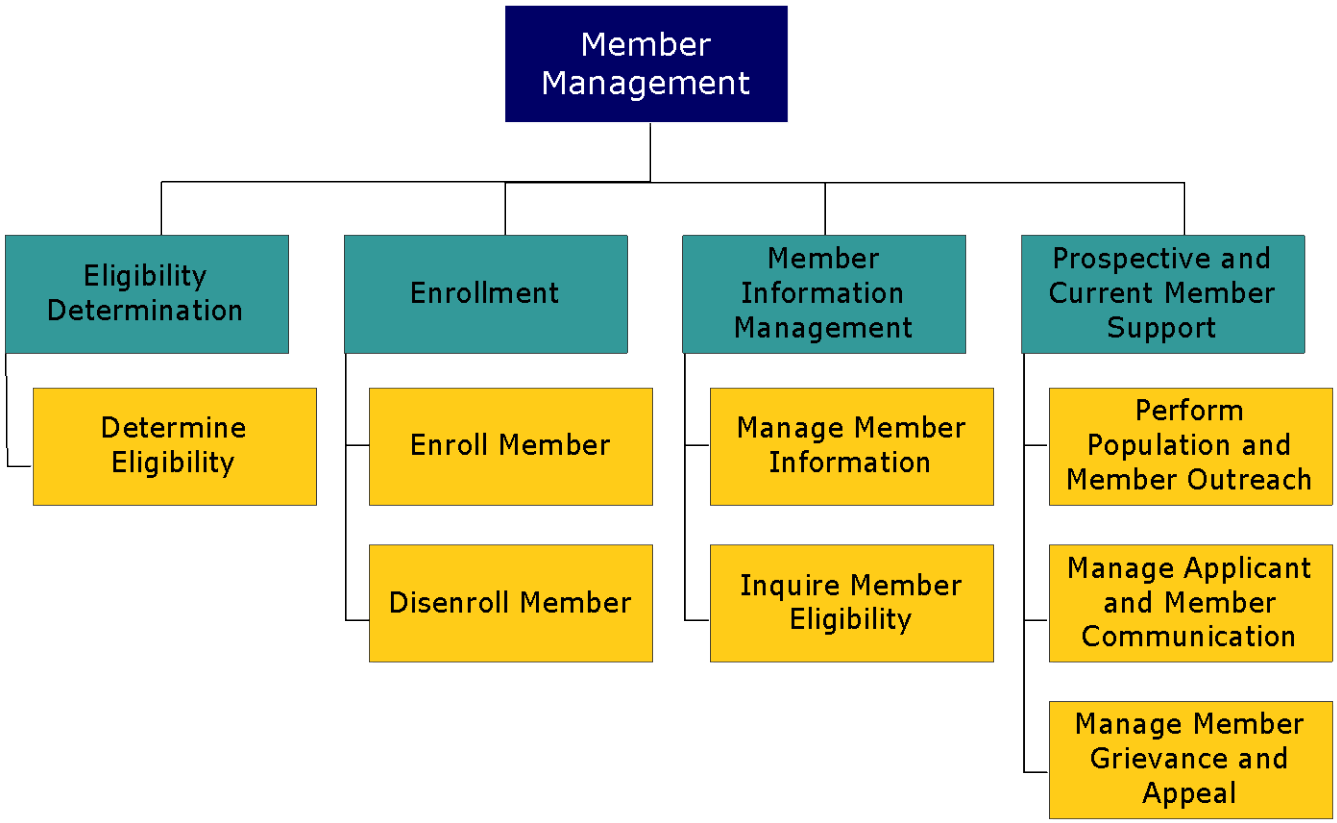


Figure 4 – MITA Member (Client) Management Business Processes

3.1.2 Findings

Outside of eligibility determination and client enrollment, the majority of Colorado's Member (Client) Management business processes are manual and lack coordination within the agency. These manual and uncoordinated processes result in additional staff resource needs to manage the workload. Determine Eligibility and Member Enrollment are exceptions in that they are primarily automated and standardized processes. Eligibility is automatically provided to, and loaded into, the MMIS from a CBMS feed that includes foster care data from the TRAILS system. MMIS accepts the eligibility and automatically enrolls the client into the appropriate benefit package(s). There is no communication loop that supports reconciliation of eligibility data between the CBMS and MMIS. Information revised due to edits in the MMIS is not shared with the CBMS (and then to TRAILS) causing downstream data integrity issues that impact everything from claims payment to client/applicant communication, to population outreach.

3.1.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Member (Client) Management business area during the "To Be"/ Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Member (Client) Management business area.

Table 5 – Member (Client) Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
Member Management	Eligibility Division	Determine Eligibility	Determine Client Eligibility		As Is	To Be			• Ability to support bi-directional interfaces (where appropriate) • Reduce lag between determination and posting data to MMIS • Centralize access to client information (by client, provider, agency, etc.) • System flexibility (ability to easily and quickly configure based on changing business requirements) • Automate workflow management • Electronic client management (incoming data, i.e. online application, and outgoing data, i.e. notices/text for baby) • Improve reporting capabilities • Audit trail and access to history (automated, online, human readable) • Standardize client communication • Ability to automate client education and communication • Improve and increase client communication to target areas (multi-language and multi-literate) • Standardize client assessment and care planning • Ability to create policy modeling and forecasting
		Enroll Member	Enroll Medicaid Client	As Is	To Be				
			Enroll CHP+ Client	As Is	To Be				
		Disenroll Member	Disenroll Client		As Is	To Be			
		Inquire Member Eligibility	Inquire Client Eligibility		As Is	To Be			
		Manage Member Information	Manage Client Information	As Is	To Be				
		Perform Population and Member Outreach	Perform Client Outreach	As Is	To Be				
		Manage Applicant and Member Communication	Manage Applicant and Client Relations	As Is	To Be				
		Manage Member Grievance and Appeal	Manage Client Appeal	As Is	To Be				

3.1.4 Transition Goals

The following table displays the mapping of the Member (Client) Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 6 – Member (Client) Management Transition Goals

Transition Goals	Member (Client) Management Business Processes							
	Determine Eligibility	Enroll Member	Disenroll Member	Inquire Member Eligibility	Manage Member Information	Perform Population and Member Outreach	Manage Applicant and Member Communication	Manage Member Grievance and Appeal
Ability to Support bi-directional interfaces	✓	✓	✓	✓	✓			
Audit trail and access to history			✓					
Automate reconciliation process			✓					
Automate workflow management			✓					
Centralize access to data	✓	✓		✓	✓	✓		✓

Transition Goals	Member (Client) Management Business Processes							
	Determine Eligibility	Enroll Member	Disenroll Member	Inquire Member Eligibility	Manage Member Information	Perform Population and Member Outreach	Manage Applicant and Member Communication	Manage Member Grievance and Appeal
Electronic Client Management	✓	✓	✓	✓	✓		✓	✓
Improve, standardize, and automate electronic communication capabilities		✓	✓		✓	✓	✓	✓
Improve electronic Care Management		✓			✓	✓	✓	
Improve internal knowledge management process			✓					
Improve reporting capabilities						✓		
Standardize processes	✓			✓	✓			✓
Standardize transactions	✓		✓	✓				
System flexibility		✓	✓	✓	✓	✓	✓	

3.2 Provider Management

3.2.1 Description

The Provider Management business area is a collection of business processes that focus on recruiting potential providers, maintaining information about the provider, and communicating with the provider community. The goal of this business area is to maintain a provider network that meets the needs of clients, supports providers, and allows the State Medicaid agency to monitor and reward provider performance and improve healthcare outcomes.

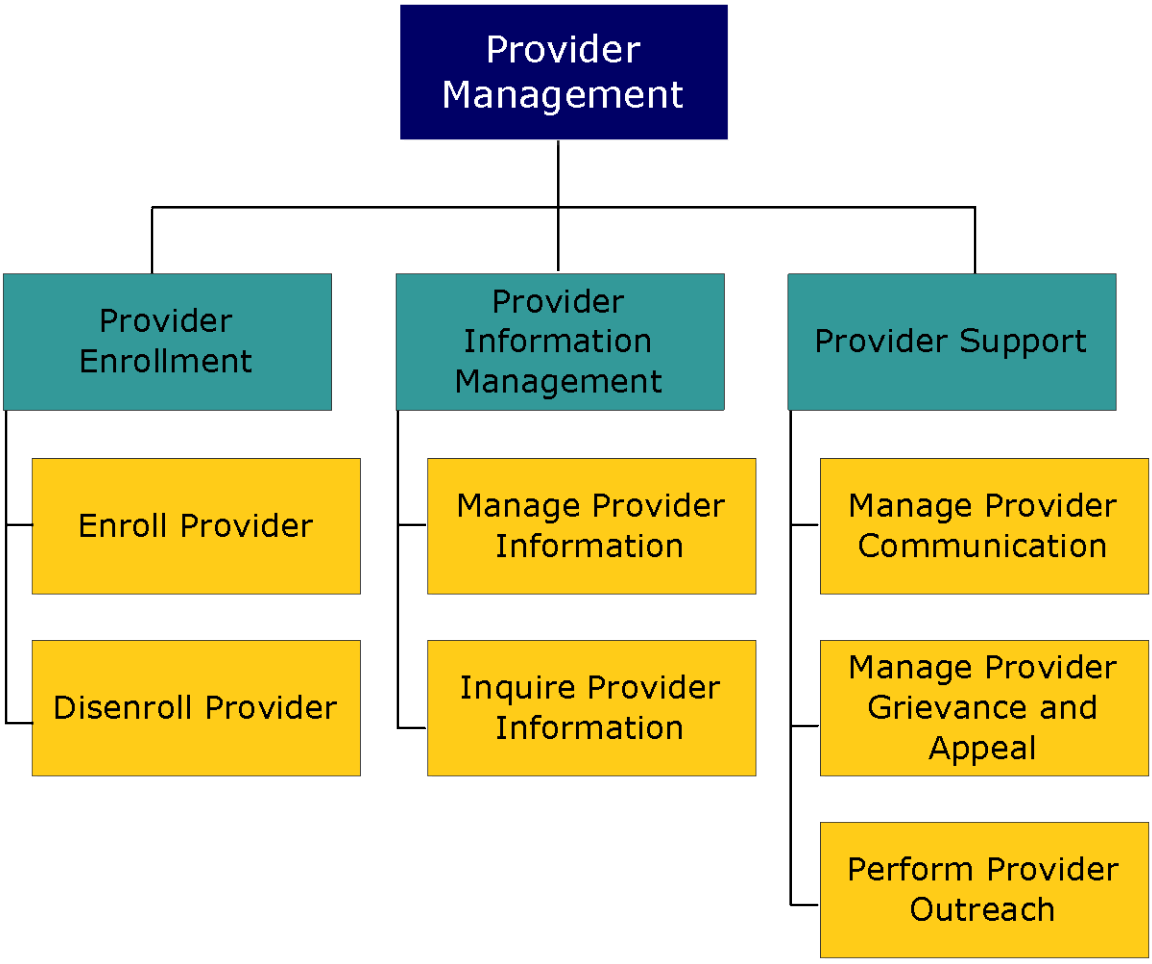


Figure 5 – *MITA Provider Management Business Processes*

3.2.2 Findings

Colorado's Provider Management business processes are primarily manual and staff intensive. Currently, the State does not have automated business rules or an online provider application. Enrolling providers requires State staff to review and verify each application. The Manage Provider Grievance and Appeal process and Perform Provider Outreach process also rely on manual intervention. Provider billing manuals and related documentation are available through the provider services website; however, documents are developed and maintained manually, then uploaded to the website.

The State has a Web Portal to provide some automation and electronic information distribution. The Web Portal's self-service business processes are not currently available to all provider types; requiring State staff or Fiscal Agent staff to enter paper claims, capture provider information updates, and to respond to provider information inquiries for provider types that do not have Web Portal access. In addition to the Web Portal, Colorado Medicaid has an automated process for program communication, but continues to maintain paper communication methods as requested by some providers.

3.2.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Provider Management business area, during the "To Be"/Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Provider Management business area.

Table 7 – Provider Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
Provider Management	Provider Services	Enroll Provider	Enroll Provider	As Is		To Be			• Ability to support bi-directional interfaces (where appropriate) • Centralize access to client and provider data • Audit trail and access to history (automated, online, and human readable) • Automate workflow management • Electronic provider management • Improve reporting capabilities • Electronic tracking of performance measures • System flexibility (ability to easily and quickly configure based on changing business requirements) • Automate and Improve communication (multi-language)
		Disenroll Provider	Disenroll Provider	As Is		To Be			
		Manage Provider Information	Manage Provider Information	As Is		To Be			
		Inquire Provider Information	Inquire Provider Information		As Is	To Be			
		Manage Provider Communication	Manage Provider Relations		As Is	To Be			
		Manage Provider Grievance and Appeal	Manage Provider Grievance and Appeal	As Is	To Be				
		Perform Provider Outreach	Perform Provider Outreach	As Is	To Be				

3.2.4 Transition Goals

The following table displays the mapping of the Provider Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 8 – Provider Management Transition Goals

Transition Goals	Provider Management Business Processes						
	Enroll Provider	Disenroll Provider	Manage Provider Information	Inquire Provider Information	Manage Provider Communication	Manage Provider Grievance & Appeal	Perform Provider Outreach
Ability to accept and store electronic attachments	✓		✓			✓	
Ability to Support bi-directional interfaces	✓		✓			✓	
Audit trail and access to history			✓		✓	✓	
Automate workflow management	✓		✓				
Centralize access to data	✓	✓		✓	✓	✓	✓
Electronic Provider Management	✓	✓	✓	✓	✓		
Electronic tracking of audit actions			✓				
Improve, standardize, and automate electronic communication capabilities		✓	✓		✓	✓	
Improve reporting capabilities			✓	✓	✓		✓
System flexibility	✓	✓		✓	✓		

3.3 Contractor Management

3.3.1 Description

The Contractor Management business area accommodates states that have managed care contracts or a variety of outsourced contracts. Some states combine Provider Management and Contractor Management into one business area. In Colorado, the Contractor Management business area owns and uses a specific set of data and includes business processes that are distinct from Provider Management.

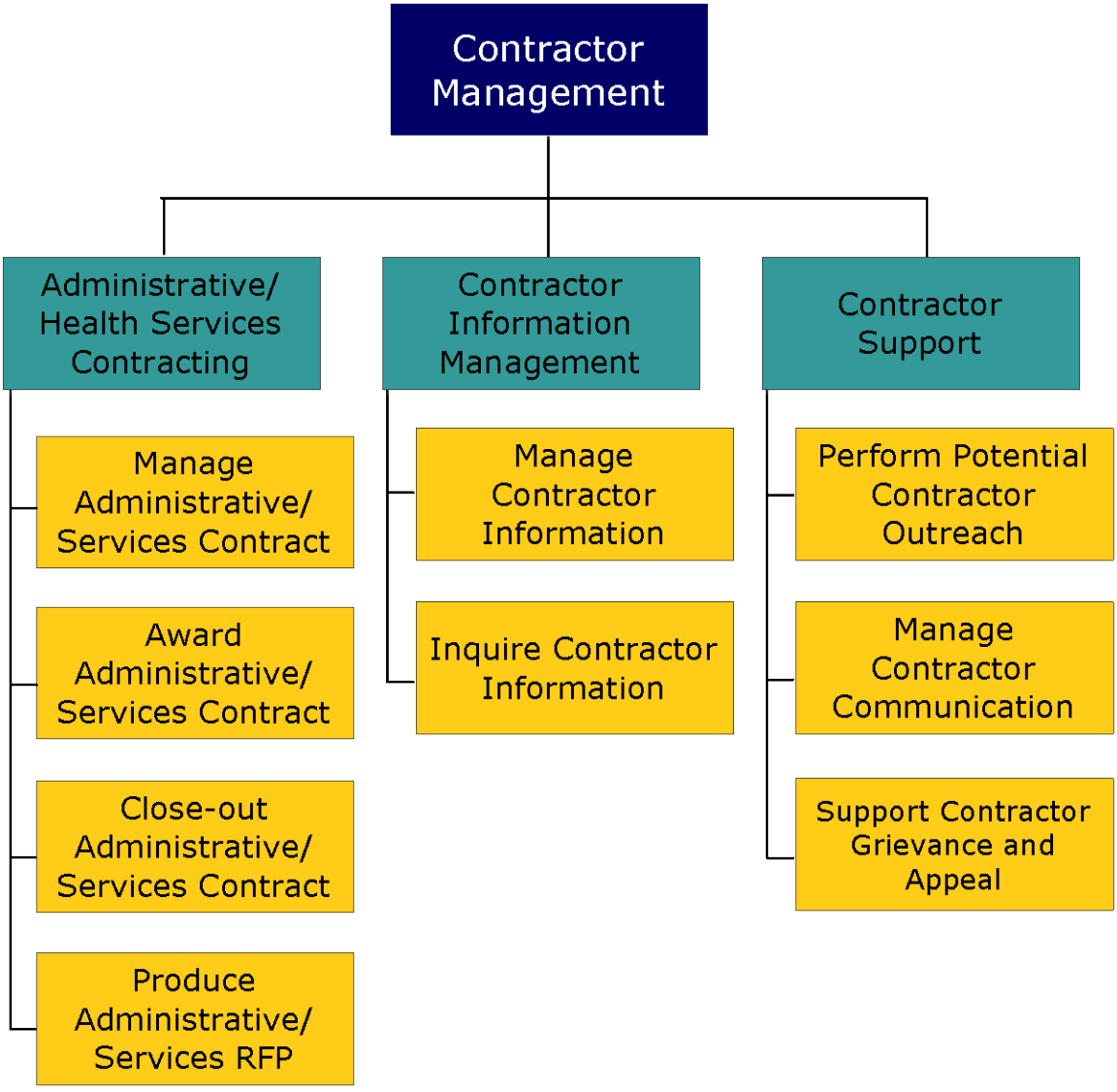


Figure 6 – MITA Contractor Management Business Processes

3.3.2 Findings

Colorado's Contractor Management business processes are manual and staff intensive but, in most cases, are well coordinated within the agency. The State uses the Bid Information Distribution System (BIDS) to electronically distribute solicitation opportunities and announce their award. Once a proposal is received via paper, disk, fax or email, State staff manually review, evaluate and, when appropriate, score proposals. All aspects of awarding the contract, monitoring the contract, communicating with contractors, answering inquiries regarding contractors, performing outreach and closing out contracts are also manual processes. State Purchasing maintains a statewide Contract Management System that is used, depending on the contract type, to track and manage information related to the contracts. However, this data does not integrate with the MMIS to assist in electronically monitoring contract performance measures. For contracts that are not maintained in the Contract Management System, the Purchasing & Contracting Services Section maintains contract information in Department-specific databases. There is no central repository to track information and status related to contract grievances and appeals.

3.3.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Contractor Management business area, during the "To Be"/ Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Contractor Management business area.

Table 9 – Contractor Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
Contractor Management	Purchasing and Contracting Services	Manage Administrative/ Health Services Contract	Manage Contract		As Is	To Be			• System flexibility (ability to easily configure based on changing business requirements) • Ability to support standard bi-directional interfaces (where appropriate) • Centralize and control access to real-time data (including documents and attachments) • Accept, store and link electronic attachments (where appropriate) • Automate workflow management • Improve reporting capabilities (and automate as appropriate) • Audit trail (automate, online, human readable) • Electronic tracking of performance measures • Improve and automate electronic communication capabilities (internally and externally) • Automate Clearance process • Standardize the contracting process (including grievances and appeals)
		Award Administrative/ Health Services Contract	Award Contract	As Is/ To Be					
		Close-out Administrative/ Health Services Contract	Close-out Contract	As Is/ To Be					
		Produce Administrative/ Health Services RFP	Produce RFP	As Is/ To Be					
	Contract Management	Manage Contractor Information	Manage Contractor Information	As Is	To Be				
		Inquire Contractor Information	Inquire Contractor Information	As Is	To Be				
		Perform Potential Contractor	Perform Potential Contractor		As Is/ To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
		Outreach	Outreach						• Electronic financial management (including budget, forecasting and payment capabilities) • Electronic utilization tracking and forecasting
		Manage Contractor Communication	Manage Contractor Communication	As Is	To Be				
		Support Contractor Grievance and Appeal	Support Contractor Grievance and Appeal	As Is	To Be				

3.3.4 Transition Goals

The following table displays the mapping of the Contractor Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 10 – Contractor Management Transition Goals

Transition Goals	Contractor Management Business Processes								
	Manage Administrative/ Health Services Contract	Award Administrative/ Health Services Contract	Close-out Administrative/Health Services Contract	Produce Administrative/ Health Services RFP	Manage Contractor Information	Inquire Contractor Information	Perform Potential Contractor Outreach	Manage Contractor Communication	Support Contractor Grievance and Appeal
Ability to accept and store electronic attachments	✓			✓			✓	✓	✓
Ability to Support bi-directional interfaces							✓	✓	
Audit trail and access to history					✓				
Automate Clearance process		✓		✓	✓				
Automate workflow management	✓	✓							
Centralize access to data	✓	✓		✓	✓		✓	✓	✓

Transition Goals	Contractor Management Business Processes								
	Manage Administrative/ Health Services Contract	Award Administrative/ Health Services Contract	Close-out Administrative/Health Services Contract	Produce Administrative/ Health Services RFP	Manage Contractor Information	Inquire Contractor Information	Perform Potential Contractor Outreach	Manage Contractor Communication	Support Contractor Grievance and Appeal
Electronic Financial Management								✓	
Electronic tracking of audit actions									✓
Electronic tracking of performance measures	✓								
Electronic utilization tracking and forecasting								✓	
Improve, standardize, and automate electronic communication capabilities	✓							✓	
Improve electronic Care Management							✓	✓	
Improve electronic Contractor Management	✓			✓	✓	✓	✓	✓	
Improve internal knowledge management process	✓	✓	✓						
Improve reporting capabilities	✓				✓			✓	

Transition Goals	Contractor Management Business Processes								
	Manage Administrative/ Health Services Contract	Award Administrative/ Health Services Contract	Close-out Administrative/Health Services Contract	Produce Administrative/ Health Services RFP	Manage Contractor Information	Inquire Contractor Information	Perform Potential Contractor Outreach	Manage Contractor Communication	Support Contractor Grievance and Appeal
Standardize processes	✓	✓	✓				✓	✓	✓
Standardize transactions							✓	✓	
System flexibility				✓				✓	

3.4 Operations Management

3.4.1 Description

The Operations Management business area is the focal point of most State Medicaid enterprises today. It includes operations that support the payment of providers, managed care organizations, other agencies, insurers, and Medicare premiums and supports the receipt of payments from other insurers, providers, and client premiums.

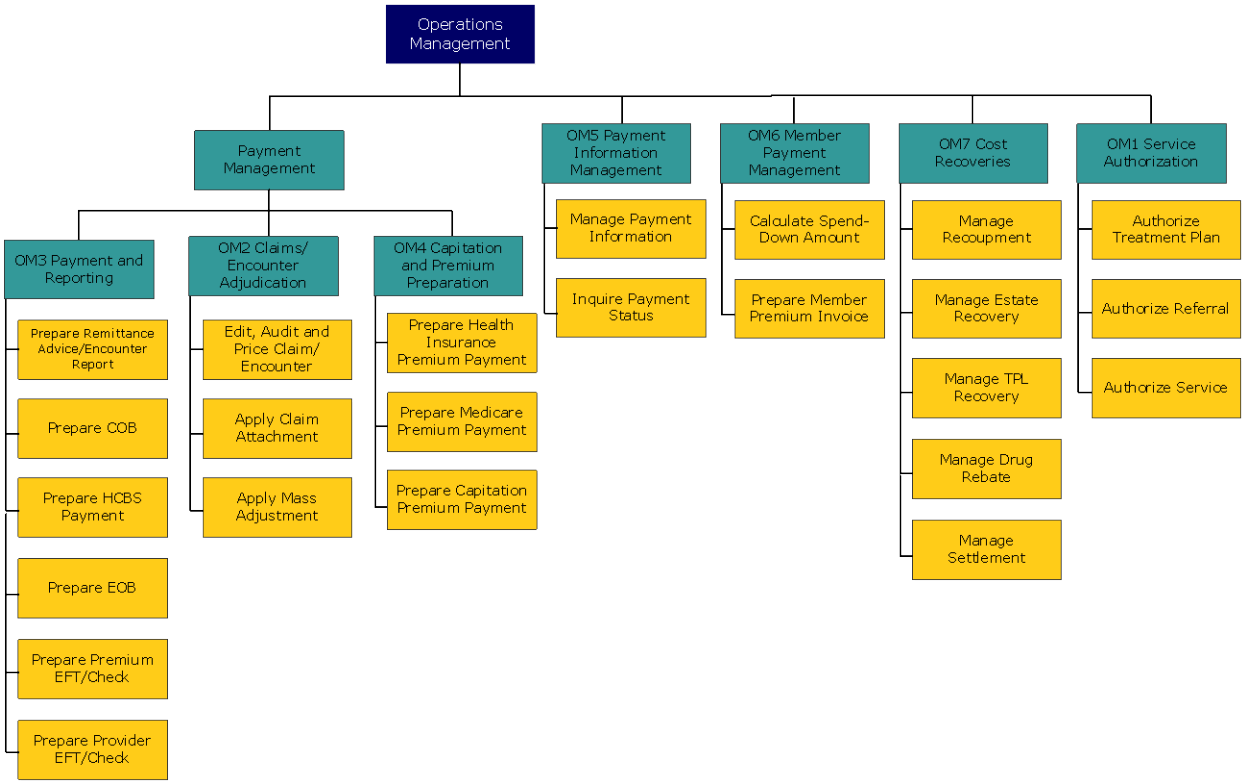


Figure 7 – MITA Operations Management Business Processes

3.4.2 Findings

Colorado's Operations Management business processes, such as authorizing services, referrals, and treatment plans are highly manual, and are staff intensive. The Pharmacy program has implemented a separate claims payment system that is able to take advantage of a number of processes to provide consistent results. The Prescription Drug Card System (PCDS) interfaces with MMIS, but not all drug related claim types are passed to the MMIS. Any reconciliation between the two systems requires manual review and intervention.

In general, Colorado's Operations Management business processes surrounding claims payment and adjudication are well coordinated and incorporate many automated processes. However, due to system configuration limitations and a large change request (CSR) backlog, the current MMIS does not include the most appropriate business rules and data validation requirements. Therefore, additional manual steps to review and edit claims have been created to support payment processing. Paper claim attachments used in the adjudication process are not centralized or easily accessible for State staff.

The Colorado Financial Reporting System (COFRS), implemented in 1991, is the statewide accounting system that interfaces with the MMIS for all payment processing. Due to the constraints of both legacy MMIS and COFRS systems, payment data provided to COFRS via an interface is limited and does not allow any opportunity to synchronize data in a way that keeps both systems accurate. As a result, State staff has implemented many manual processes to maintain and update necessary MMIS information used for fiscal analysis and reporting. State staff are also required to develop and produce multiple reports in order to manually reconcile payment data with claims data for reconciliation and auditing purposes.

Preparation of payment reporting is primarily automated, but there are many opportunities to streamline access to the information used to compile the reports. Information used to generate payment reports is not included in the DSS and requires State staff to run reports from multiple sources that may not contain information from the same point in time. Additional manual validation steps have been implemented to ensure accurate reporting.

Colorado's Third Party Liability (TPL) business processes include a combination of automated and manual processes. The MMIS receives a standard interface from CBMS, which has been designed to overwrite the eligibility data in the MMIS. This overwrite process creates a number of issues for MMIS business processes. For TPL specifically, this removes historical eligibility data and overwrites important information needed to support recoupment. Colorado's TPL and recovery identification opportunities are reliant on manual processes. The lack of historical eligibility data requires additional manual intervention. The involvement of a TPL contractor augments the process and has established an effective means of recovery; however, the current MMIS lacks a robust TPL tracking and validation that would allow the State staff to strengthen Colorado's cost avoidance capabilities.

3.4.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Operations Management business area during the "To Be"/ Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Operations Management business area.

Table 11 – Operations Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
Operations Management	Agency Administration and Operations	Authorize Referral	Prior Authorization	As Is	To Be				• System flexibility (ability to easily and quickly configure based on changing business requirements) • Ability to support standard bi-directional interfaces (where appropriate) • Centralize access to real-time client and provider data • Centralize access to benefit data for all programs • Accept, store and link electronic attachments (where appropriate) • Automate workflow management • Improve reporting capabilities (and automate as appropriate) including leveraging meaningful use • Audit trail and access to history (automate, online, and human-readable) • Electronic tracking of performance measures
		Authorize Service	Prior Authorization	As Is	To Be				
		Authorize Treatment Plan	Define Benefit Packages	As Is	To Be				
		Apply Claim Attachment	Apply Claim Attachment	As Is	To Be				
		Apply Mass Adjustment	Apply Mass Adjustment	As Is	To Be				
		Edit, Audit, Price Claim/ Encounter	Edit, Audit, Price Claim/ Encounter		As Is	To Be			
		Prepare Remittance Advice/ Encounter Report	Prepare Remittance Advice/ Encounter Report		As Is	To Be			
		Prepare COB	N/A	Colorado does not perform this business process					
		Prepare EOB	Prepare EOMB	As Is	To Be				
		Prepare HCBS Payment	Prepare HCBS Payment		As Is	To Be			
		Prepare Provider EFT/Check	Prepare Provider EFT		As Is/ To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
		Prepare Premium EFT/Check	Prepare Premium EFT/Check		As Is/ To Be				• Electronic financial management • Electronic Provider Management • Improve and automate electronic communication capabilities • Improve coordination between case management agency, county and department
		Prepare Health Insurance Premium Payment	Prepare HIBI Payment	As Is	To Be				
		Prepare Medicare Premium Payment	Medicare Buy-in Process		As Is	To Be			
		Prepare Capitation Premium Payment	Prepare Capitation Premium Payment		As Is	To Be			
		Manage Payment Information	Manage Changes & Reconcile Capitated Payment Information	As Is	To Be				
		Inquire Payment Status	Inquire Payment Status		As Is	To Be			
		Calculate Spend-Down Amount	Calculate Spend-Down Amount	Colorado does not perform this process.					
		Prepare Member Premium Invoice	Prepare Member Premium Invoice	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
		Manage Recoupment	Manage Recoupment	As Is	To Be				
		Manage Estate Recovery	Manage Estate Recovery	As Is	To Be				
		Manage TPL Recovery	Manage TPL Recovery	As Is	To Be				
		Manage Drug Rebate	Manage Drug Rebate		As Is	To Be			
		Manage Settlement	Manage Cost Settlement	As Is	To Be				

3.4.4 Transition Goals

The following tables display the mapping of the Operations Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 12 – Operations Management Transition Goals

Transition Goals	**Operations Management -** Service Authorization, Claims/Encounter Adjudication, Payment and Reporting, Capitation and Premium Preparation														
	Authorize treatment plan	Authorize referral	Authorize service	Edit/Audit/Price Claim/Encounter	Apply Attachment	Apply Mass Adjustment	Prepare remittance advice/encounter	Prepare COB	Prepare HCBS payments	Prepare EOB	Prepare provider EFT/Checks	Prepare premium EFT/Checks	Prepare health insurance premium	Prepare Medicare premium payments	Prepare capitation premium payments
Ability to accept and store electronic attachments	✓		✓	✓	✓										
Ability to Support bi-directional interfaces	✓	✓	✓		✓				✓				✓	✓	✓
Audit trail and access to history	✓													✓	
Automate reconciliation process												✓		✓	✓
Automate workflow			✓	✓		✓							✓	✓	

Transition Goals	**Operations Management -** Service Authorization, Claims/Encounter Adjudication, Payment and Reporting, Capitation and Premium Preparation														
	Authorize treatment plan	Authorize referral	Authorize service	Edit/Audit/Price Claim/Encounter	Apply Attachment	Apply Mass Adjustment	Prepare remittance advice/encounter	Prepare COB	Prepare HCBS payments	Prepare EOB	Prepare provider EFT/Checks	Prepare premium EFT/Checks	Prepare health insurance premium	Prepare Medicare premium payments	Prepare capitation premium payments
management															
Centralize access to data		✓	✓				✓		✓	✓		✓		✓	
Electronic Client Management	✓	✓								✓			✓	✓	
Electronic Financial Management						✓					✓	✓	✓	✓	✓
Electronic Provider Management	✓	✓	✓				✓					✓			
Electronic tracking of audit actions	✓	✓													
Electronic utilization tracking and forecasting															✓
Improve, standardize, and automate electronic communication capabilities		✓				✓				✓				✓	
Improve electronic Care Management	✓	✓	✓						✓						

Transition Goals	**Operations Management -** Service Authorization, Claims/Encounter Adjudication, Payment and Reporting, Capitation and Premium Preparation														
	Authorize treatment plan	Authorize referral	Authorize service	Edit/Audit/Price Claim/Encounter	Apply Attachment	Apply Mass Adjustment	Prepare remittance advice/encounter	Prepare COB	Prepare HCBS payments	Prepare EOB	Prepare provider EFT/Checks	Prepare premium EFT/Checks	Prepare health insurance premium	Prepare Medicare premium payments	Prepare capitation premium payments
Improve internal knowledge management process	✓														
Improve reporting capabilities	✓					✓	✓			✓		✓	✓	✓	✓
Reduce lag between determination and posting data to MMIS			✓												✓
Standardize processes	✓	✓								✓					
Standardize transactions	✓						✓			✓			✓	✓	✓
System flexibility	✓	✓		✓		✓	✓			✓		✓	✓	✓	✓

Table 13 – Operations Management Transition Goals (Continued)

Transition Goals	**Operations Management -** Payment Information Management, Member Payment Management, Cost Recoveries								
	Manage Payment Information	Inquire Payment Status	Calculate Spend-Down Amount	Prepare Member Premium Invoice	Manage Recoupment	Manage Estate Recovery	Manage TPL Recovery	Manage Drug Rebate	Manage Cost Settlement
Ability to accept and store electronic attachments				✓					
Ability to Support bi-directional interfaces		✓				✓	✓	✓	
Audit trail and access to history					✓				
Automate reconciliation process		✓							
Automate workflow management					✓		✓		
Centralize access to data		✓		✓			✓	✓	
Electronic Client Management				✓		✓			
Electronic Financial Management				✓	✓		✓		✓
Electronic Provider Management		✓		✓	✓				
Electronic tracking of audit actions					✓				
Electronic utilization tracking and forecasting								✓	

Transition Goals	**Operations Management -** Payment Information Management, Member Payment Management, Cost Recoveries								
	Manage Payment Information	Inquire Payment Status	Calculate Spend-Down Amount	Prepare Member Premium Invoice	Manage Recoupment	Manage Estate Recovery	Manage TPL Recovery	Manage Drug Rebate	Manage Cost Settlement
Improve, standardize, and automate electronic communication capabilities		✓							
Improve electronic Contractor Management		✓		✓					
Improve internal knowledge management process								✓	
Improve reporting capabilities		✓							✓
Increase staffing								✓	
Standardize processes							✓		
Standardize transactions				✓		✓	✓	✓	✓
System flexibility	✓	✓		✓	✓			✓	✓

3.5 Program Management

3.5.1 Description

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

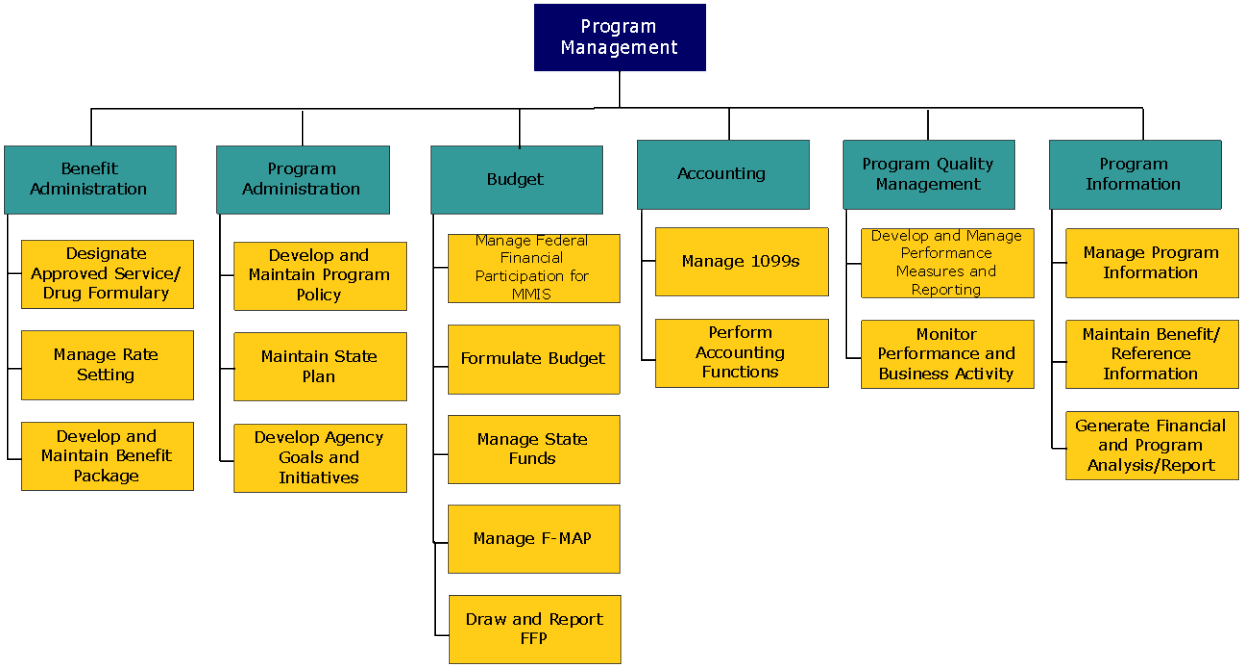


Figure 8 – MITA Program Management Business Processes

3.5.2 Findings

Colorado's Program Management business processes are mainly manual, lack coordination within the agency and are staff intensive. Overall, the manual clearance process was consistently noted as a roadblock to quick implementation and approval of programs, policy, change requests, etc.

Colorado does not have a standardized process to coordinate and maintain historical program administration and historical policy decisions. Specifically, the MMIS focuses on payment/claims adjudication and does not have features or functionality that easily support program/policy staff decision tracking or impact inquiries. Information gathered for program evaluation, performance measurement, and federal reporting is decentralized making the manual process very time intensive. Additionally, Colorado's case management information is not integrated with eligibility information or claims information (Benefits Utilization System (BUS), MMIS, CBMS do not synchronize data) creating further reporting complications. Inconsistent data sources used to report performance measure findings result in information that lacks credibility with contractors.

A large concern for the State is the MMIS has a limited ability to track, report, and handle multiple pricing structures for both Managed Care encounters and fee-for-service claims. This regularly creates conflicts when establishing new benefit packages and requires additional manual workarounds to enter appropriate data for claim/encounter adjudication.

3.5.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Program Management business area, during the "To Be"/Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Program Management business area.

Table 14 – Program Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
Program Management	Program/ Policy Manage-ment	Designate Approved Service/Drug Formulary	Designate Approved Service Formulary	As Is		To Be			• Improve reporting capabilities (and automate as appropriate) and support meaningful use • Increase staffing • Ability to support standard bi-directional interfaces (where appropriate) • System flexibility (ability to easily and quickly configure based on changing business requirements) • Improve and automate electronic communication capabilities (clients and providers) • Audit trail and access to history (automated, online, human-readable) • Centralize data access to real-time benefit data for all programs (Foster care, Medicaid, CHP+, LTC) • Automate workflow management
			Designate Approved Drug Formulary	As Is		To Be			
		Manage Rate Setting	Manage Rate Setting	As Is		To Be			
		Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	As Is		To Be			
		Manage Federal Financial Participation for MMIS	Manage FFP	As Is	To Be				
		Formulate Budget	Manage Budget	As Is	To Be				
		Manage State Funds	Manage State Funds	As Is	To Be				
		Draw and Report FFP	Draw and Report FFP	As Is	To Be				
		Manage F-MAP	Manage F-MAP	As Is	To Be				
		Manage 1099s	Manage 1099s	As Is	To Be				
		Perform Accounting Functions	Accounting	As Is	To Be				
		Develop and Maintain Program	Develop and Maintain	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
		Policy	Program Policy						• Electronic tracking of performance measures • Automate Clearance process • Automated forecasting and policy modeling • Electronic financial management (including budget and payment capabilities) • Electronic Provider Management • Automate reconciliation process
		Maintain State Plan	Maintain State Plan	As Is	To Be				
		Develop Agency Goals and Objectives	Develop Agency Goals and Objectives	As Is	To Be				
		Develop and Manage Performance Measures and Reporting	Develop and Manage Performance Measures and Reporting	As Is	To Be				
		Monitor Performance and Business Activity	Monitor Performance and Business Activity	As Is		To Be			
		Manage Program Information	Manage Program Information	As Is	To Be				
		Maintain Benefits Reference Information	Maintain Benefits Reference Information	As Is	To Be				
		Generate Financial and Program Analysis Report	Generate Financial and Program Analysis Report		As Is	To Be			

3.5.4 Transition Goals

The following tables display the mapping of the Program Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 15 – Program Management Transition Goals

Transition Goals	**Program Management -** Benefit Administration, Budget, Accounting									
	Designate approved services & drug formulary	**Manage Rate Setting**	**Develop & Maintain Benefit Package**	**Manage FFP for MMIS**	**Manage FFP for Services/F-MAP**	**Formulate budget**	**Manage State Funds**	**Draw and report FFP**	**Manage 1099s**	**Perform accounting functions**
Ability to Support bi-directional interfaces	✓	✓	✓	✓	✓				✓	✓
Audit trail and access to history	✓							✓		
Automate Clearance process				✓						
Automate reconciliation process					✓			✓		✓
Automate workflow management	✓			✓	✓		✓		✓	✓
Centralize access to data		✓	✓			✓	✓			✓
Electronic Financial					✓	✓	✓	✓		✓

Transition Goals	Program Management - Benefit Administration, Budget, Accounting									
	Designate approved services & drug formulary	Manage Rate Setting	Develop & Maintain Benefit Package	Manage FFP for MMIS	Manage FFP for Services/F-MAP	Formulate budget	Manage State Funds	Draw and report FFP	Manage 1099s	Perform accounting functions
Management										
Electronic Provider Management	✓								✓	
Electronic tracking of performance measures			✓							
Improve, standardize, and automate electronic communication capabilities		✓							✓	
Improve electronic Contractor Management									✓	
Improve internal knowledge management process							✓			✓
Improve reporting capabilities	✓		✓	✓		✓	✓	✓		✓
Increase staffing	✓									

Transition Goals	**Program Management -** Benefit Administration, Budget, Accounting									
	Designate approved services & drug formulary	Manage Rate Setting	Develop & Maintain Benefit Package	Manage FFP for MMIS	Manage FFP for Services/F-MAP	Formulate budget	Manage State Funds	Draw and report FFP	Manage 1099s	Perform accounting functions
Reduce lag between determination and posting data to MMIS		✓								
Standardize processes			✓	✓	✓		✓			✓
Standardize transactions	✓			✓	✓					✓
System flexibility	✓	✓	✓	✓	✓		✓	✓		✓

Table 16 – Program Management Transition Goals (continued)

Transition Goals	**Program Management -** Program Administration, Program Quality Management, Program Information							
	Develop and maintain program policy	Maintain state plan	Develop agency goals and objectives	Develop and manage performance measures and reporting	Monitor performance and business activity	Manage program information	Maintain benefits reference information	Generate financial and program analysis report
Ability to accept and store electronic attachments		✓						
Ability to create policy and utilization modeling and forecasting	✓							
Ability to Support bi-directional interfaces	✓			✓	✓	✓		
Audit trail and access to history		✓						
Automate workflow management	✓	✓		✓				✓
Centralize access to data				✓	✓	✓	✓	
Electronic Client Management				✓	✓	✓		
Electronic Financial Management								✓
Electronic Provider Management				✓				
Electronic tracking of performance			✓	✓				

Transition Goals	**Program Management** - Program Administration, Program Quality Management, Program Information							
	Develop and maintain program policy	Maintain state plan	Develop agency goals and objectives	Develop and manage performance measures and reporting	Monitor performance and business activity	Manage program information	Maintain benefits reference information	Generate financial and program analysis report
measures								
Improve, standardize, and automate electronic communication capabilities	✓							
Improve electronic Care Management				✓				
Improve electronic Contractor Management						✓		
Improve internal knowledge management process	✓	✓	✓				✓	
Improve reporting capabilities			✓	✓	✓	✓		✓
Standardize processes	✓	✓	✓		✓		✓	
Standardize transactions				✓	✓	✓	✓	
System flexibility	✓			✓	✓	✓	✓	✓

3.6 Program Integrity Management

3.6.1 Description

The Program Integrity business area incorporates those business activities that focus on program compliance (e.g., auditing and tracking medical necessity and appropriateness of care and quality of care, fraud and abuse, erroneous payments, and administrative abuses).

Program Integrity collects information about an individual provider or client (e.g., demographics; information about the case itself such as case manager ID, dates, actions, and status; and information about parties associated with the case). The business processes in this business area have a common purpose (e.g., to identify case, gather information, verify information, develop case, report on findings, make referrals, and resolve case). As with the previous business areas, a single business process may cover several types of cases. The input, output, shared data, and the business rules may differ by type of case, but the business process activities remain the same.

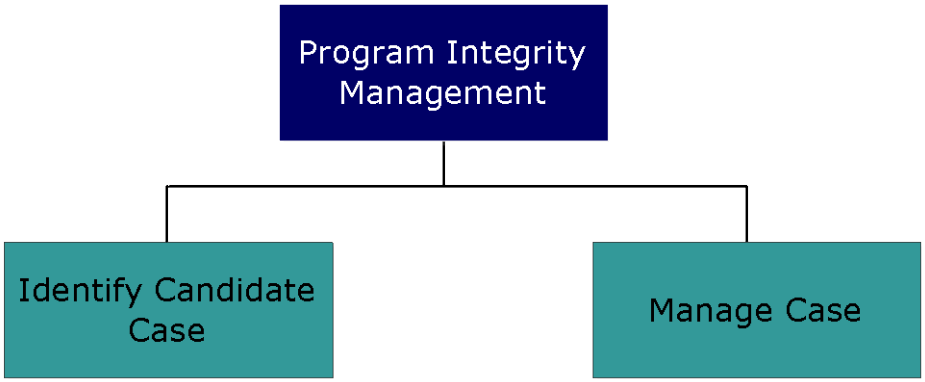


Figure 9 – MITA Program Integrity Management Business Processes

3.6.2 Findings

Colorado's Program Integrity business processes are very manual and time intensive. Cases are identified by referral, client Explanation of Medical Benefits (EOMB) responses, or through manual development of reports that target data groups or patterns. Once a case has been established, additional data is manually gathered and analyzed to determine what actions will be necessary. Processes related to coordination of required course of action; including communication with the provider, money recovery and applying monies appropriately are all manual.

3.6.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Program Integrity Management business area, during the "To Be"/ Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Program Integrity Management business area.

Table 17 – Program Integrity Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
Program Integrity Management	Program Integrity	Identify Candidate Case	Identify Candidate Case	As Is	To Be				• Ability to support standard bi-directional interfaces (where appropriate) • Centralize and control access to real-time data • Automate workflow management • Electronic Provider Management • Electronic tracking of audit actions (incorporate CORATET) • Improve and automate electronic notification capabilities (internally and externally) • System flexibility (ability to easily configure based on changing business requirements) • Improve reporting capabilities (and automate as appropriate) • Audit trail and historical access (automate, online, human readable)
		Manage Case	Manage Case	As Is		To Be			

3.6.4 Transition Goals

The following table displays the mapping of the Program Integrity Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 18 – Program Integrity Management Transition Goals

Transition Goals	Program Integrity Management Business Processes	
	Identify Candidate Case	Manage Case
Ability to accept and store electronic attachments	✓	
Ability to Support bi-directional interfaces	✓	✓
Audit trail and access to history		✓
Automate workflow management		✓
Centralize access to data	✓	✓
Electronic Provider Management	✓	✓
Electronic tracking of audit actions	✓	✓
Improve reporting capabilities	✓	✓
Standardize processes		✓
Standardize transactions	✓	✓
System flexibility	✓	✓

3.7 Business Relationship Management

3.7.1 Description

The Business Relationship Management business area is currently represented in many states as a component of Program Management. It is shown here as a separate business area because collaboration between in-state agencies and inter-state and federal agencies is increasing in importance.

This business area owns the standards for interoperability between the agency and its partners. It contains business processes that have a common purpose (e.g., establish the interagency service agreement, identify the types of information to be exchanged, identify security and privacy requirements, define communication protocol, and oversee the transfer of information.)

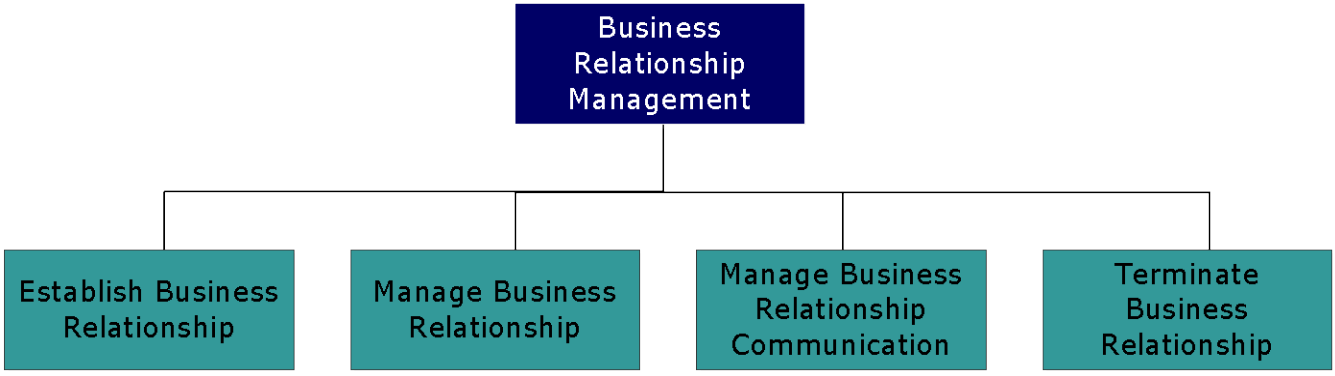


Figure 10 – MITA Business Relationship Management Business Processes

3.7.2 Findings

Colorado's Business Relationship Management business processes are mainly manual. However, the process of implementing the agreements with other agencies, contractors and providers is largely standardized and coordinated within the agency. Currently, the State does not maintain a central and secure location to manage the exchange of data.

3.7.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Business Relationship Management business area, during the "To Be"/Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Business Relationship Management business area.

Table 19 – Business Relationship Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
Business Relationship Management	Legal/ Purchasing and Contracting	Establish Business Relationship	Establish Business Relationship	As Is	To Be				• Automate Clearance process • Automate workflow management • Improve electronic contractor management • Improve and automate electronic communication capabilities (internally and externally) • Increase staffing
		Terminate Business Relationship	Terminate Business Relationship	As Is	To Be				
		Manage Business Relationship	Manage Business Relationship	As Is		To Be			
		Manage Business Relationship Communication	Manage Business Relationship Communication	[No current process in place]	To Be				

3.7.4 Transition Goals

The following table displays the mapping of the Business Relationship Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 20 – Business Relationship Management Transition Goals

Transition Goals	Business Relationship Management Business Processes			
	Establish Business Relationship	Terminate Business Relationship	Manage Business Relationship	Manage Business Relationship Communication
Automate Clearance process	✓			
Increase staffing			✓	
Standardize processes			✓	✓
Standardize transactions		✓		
System flexibility			✓	

3.8 Care Management

3.8.1 Description

Care Management collects information about the needs of the individual client, plan of treatment, targeted outcomes, and the individual's health status. It also contains business processes that have a common purpose (e.g., identify clients with special needs, assess needs, develop treatment plan, monitor and manage the plan, and report outcomes). This business area includes processes that support individual care management and population management. Population management targets groups of individuals with similar characteristics and needs and promotes health education and awareness.

With individual client and case manager access to clinical data and treatment history, Care Management continues to evolve and increase in importance in Colorado's Medicaid enterprise. This section includes information related to programs such as: Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Population Management; Patient Self-Directed Care Management; Immunization and other registries, and Waiver Program Case Management. As Colorado's Medicaid enterprise evolves, all clients could have access to care management, including self-directed decision-making.

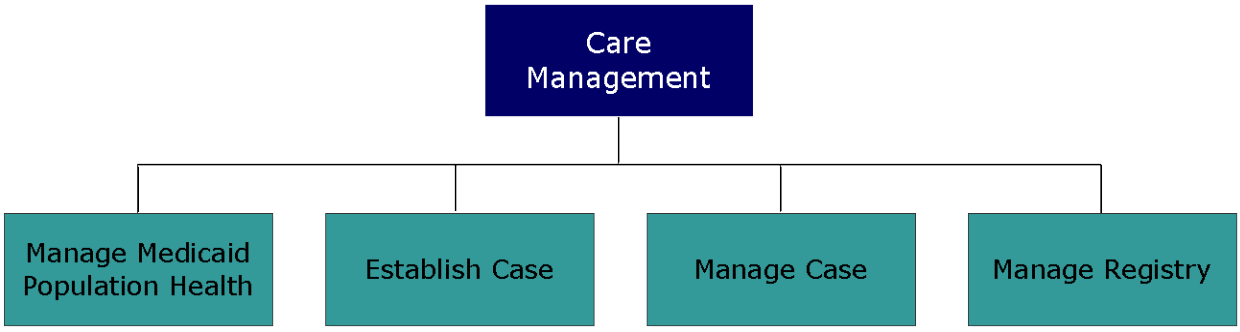


Figure 11 – MITA Care Management Business Processes

3.8.2 Findings

Colorado's processes around Care Management are highly manual, lack coordination within the agency and are staff intensive. Discussions around care management indicate that staffing levels are insufficient to manage the workload. There is no interface between MMIS, CBMS and the Long Term Care Case Management system, called the Benefits

Utilization System (BUS), requiring staff to review multiple systems to determine the appropriate and accurate level of care for clients. In addition, SMEs felt that the lack of standardization, combined with the complexity of reviewing data in multiple systems to assess appropriate services, occasionally leads to over-authorization of services.

3.8.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Care Management business area during the "To Be"/Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Care Management business area.

Table 21 – Care Management Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be "Capability 3-5 Year Timeframe
				1	2	3	4	5	
Care Management	Client Services	Manage Medicaid Population Health	Manage Medicaid Population Health	As Is		To Be			• Ability to support standard bi-directional interfaces (where appropriate) • Automate workflow management • Centralize and control access to real-time data (including documents and attachments) • Improve electronic Care Management • Ability to create utilization models and forecasting • Improve and automate electronic communication capabilities (internally and externally) • Improve and increase communication to target areas (multi-language and multi-literate) • Improve reporting capabilities (and automate as appropriate) • Standardize communication • System flexibility (ability to easily and quickly configure based on changing business requirements)
		Establish Case	Establish Case	As Is		To Be			
		Manage Case	Manage Case	As Is		To Be			
		Manage Registry	Manage Registry	As Is	To Be				

3.8.4 Transition Goals

The following table displays the mapping of the Care Management business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 22 – Care Management Transition Goals

Transition Goals	Care Management Business Processes			
	Manage Medicaid Population Health	Establish Case	Manage Case	Manage Registry
Ability to Support bi-directional interfaces	✓	✓	✓	
Automate workflow management		✓		
Centralize access to data	✓	✓	✓	
Electronic Client Management		✓	✓	
Electronic tracking of performance measures		✓	✓	
Improve, standardize, and automate electronic communication capabilities	✓	✓		
Improve electronic Care Management		✓	✓	
Improve reporting capabilities	✓	✓		✓
Standardize processes		✓	✓	
System flexibility		✓	✓	

3.9 Managed Care

3.9.1 Description

Colorado's Medicaid Managed Care documentation covers applicable business processes from each MITA business area, as they apply specifically to the Managed Care program. Managed Care was treated as a separate business area due to the distinct differences between Managed Care business processes and the fee-for-service business processes, which in some cases differed in their business capability levels. This section addresses findings and MMIS impacts when the process differs from the fee-for-service program. The Managed Care Use Cases in Appendix D detail any business processes that are unique to the Managed Care program and differ from the fee-for-service program.

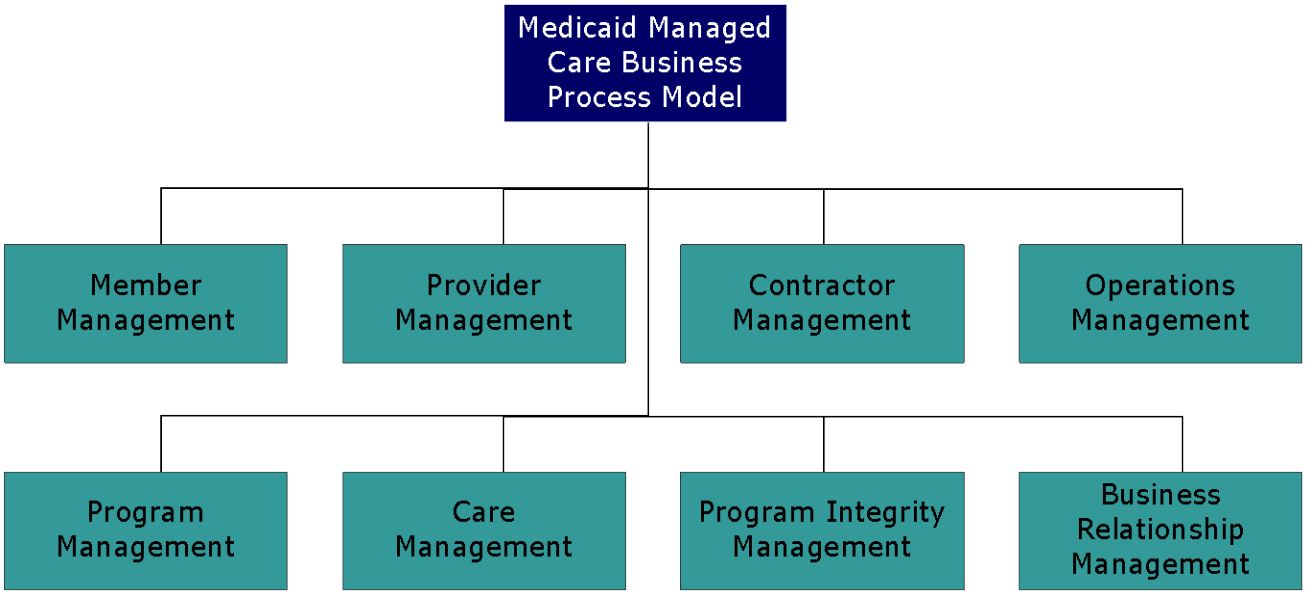


Figure 12 – MITA Managed Care Business Processes

3.9.2 Findings

Findings related to Colorado's Managed Care business processes are largely the same for: Contractor Management, Member (Client) Management, Business Relationship Management business areas.

Currently, the MMIS does not completely support the needs of the Managed Care encounters causing a large number of process workarounds. While some Managed Care business processes are automated, there are several manual processes that are not present for many of the fee-for-service business processes. Currently, CHP+ claims processing and adjudication is performed by an ASO and the encounter information is not included within the MMIS.

3.9.3 Roadmap

The following table was used to present and validate the "As Is" and "To Be" states for each business process in the Managed Care business processes, during the "To Be"/Roadmap session. Colorado Medicaid plans to transition from their current Level 1 business capability, to an overall Level 2 for the Managed Care business processes.

Table 23 – Managed Care Business Area Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
Member Management	Managed Care	Determine Eligibility	Determine Eligibility		As Is	To Be			• Ability to accept and store electronic attachments • Ability to support standard bi-directional interfaces (where appropriate) • Audit trail and access to history (automated, online, human-readable) • Automate Clearance process • Automate reconciliation process • Automate workflow management • Automate forecasting and policy modeling • Centralize data access to real-time benefit data for all programs (Foster care, Medicaid, CHP+, LTC) • Electronic financial management (including budget and payment capabilities) • Electronic Provider Management • Electronic tracking of
		Enroll Member	Enroll Member (Client)		As Is	To Be			
		Disenroll Member	Disenroll Member (Client)		As Is/ To Be				
Provider Management	Managed Care	Enroll Provider	Enroll Provider	As Is	To Be				
Contractor Management	Managed Care	Award Administrative/ Health Services Contract	Award Contract	As Is/ To Be					
		Manage Administrative/ Health Services Contract	Manage Contract	As Is	To Be				
Operations Management	Managed Care	Prepare Capitation and Premium Payment	Prepare Capitation and Premium Payment		As Is	To Be			
		Manage Payment Information	Manage Changes & Reconcile Capitated Payment Information	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability 3-5 Year Timeframe
				1	2	3	4	5	
		Prepare Member Premium Invoice	Member Payment Management	As Is	To Be				performance measures • Improve and automate electronic communication capabilities (clients and providers) • Improve internal knowledge management process • Improve reporting capabilities, automate as appropriate and support meaningful use • Increase staffing • Standardize transactions (encounter data) • System flexibility (ability to easily and quickly configure based on changing business requirements)
Program Management	Managed Care	Manage Rate Setting	Rate Setting	As Is		To Be			
		Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	As Is		To Be			
		Perform Accounting Functions	Accounting	As Is	To Be				

3.9.4 Transition Goals

The following table displays the mapping of the Managed Care business processes to the transition goals identified for this business area. This mapping illustrates how each of the business processes will transition from their current "As Is" state to their projected "To Be" state. The transition goals are influenced by federal and state initiatives, including agency goals and objectives.

Table 24 – Managed Care Transition Goals

Transition Goals	Managed Care Business Processes											
	Determine Eligibility	Enroll Member	Disenroll Member	Enroll Provider	Award Administrative/Health Services Contract	Manage Administrative/Health Services Contract	Prepare Capitation & Premium Payment	Manage Payment Information	Prepare Member Premium Invoice	Manage Rate Setting	Develop & Maintain Benefit Package	Perform Accounting Functions
Ability to accept and store electronic attachments						✓			✓			
Ability to Support bi-directional interfaces	✓	✓	✓	✓			✓			✓	✓	✓
Audit trail and access to history	✓	✓	✓	✓						✓	✓	✓
Automate reconciliation process			✓									✓
Automate workflow management			✓	✓	✓	✓						✓

Transition Goals	Managed Care Business Processes											
	Determine Eligibility	Enroll Member	Disenroll Member	Enroll Provider	Award Administrative/Health Services Contract	Manage Administrative/Health Services Contract	Prepare Capitation & Premium Payment	Manage Payment Information	Prepare Member Premium Invoice	Manage Rate Setting	Develop & Maintain Benefit Package	Perform Accounting Functions
Centralize access to data	✓	✓	✓	✓	✓	✓			✓	✓	✓	✓
Electronic Client Management	✓	✓	✓						✓			
Electronic Financial Management							✓		✓			✓
Electronic Provider Management				✓					✓			
Electronic tracking of audit actions						✓						
Electronic tracking of performance measures						✓					✓	
Electronic utilization tracking and forecasting							✓					
Improve, standardize, and automate electronic communication capabilities										✓		

Transition Goals	Managed Care Business Processes											
	Determine Eligibility	Enroll Member	Disenroll Member	Enroll Provider	Award Administrative/Health Services Contract	Manage Administrative/Health Services Contract	Prepare Capitation & Premium Payment	Manage Payment Information	Prepare Member Premium Invoice	Manage Rate Setting	Develop & Maintain Benefit Package	Perform Accounting Functions
Improve electronic Contractor Management					✓	✓			✓			
Improve internal knowledge management process					✓	✓						✓
Improve reporting capabilities	✓	✓	✓				✓			✓	✓	✓
Standardize processes	✓	✓	✓		✓	✓				✓	✓	✓
Standardize transactions	✓	✓	✓				✓		✓	✓	✓	✓
System flexibility	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓

Appendices

The following appendices are included in this report:

Appendix A: Document Change History

Appendix B: Business Capability Matrix (BCM) – CMS Format

Appendix C: Use Case Participants

Appendix D: Use Cases

Appendix E: Comprehensive MITA Roadmap

Appendix F: Initiatives Impacting the Colorado Medicaid Program

Appendix A - Document Change History

Revision History

Revision Number	Revision Date	Summary of Changes	Changes marked
0.1	1/25/2012	Initial draft for internal review	No
0.2	1/30/2012	Internal review comments incorporated	No
3.0	1/31/2012	Draft for Department review	No
4.0	2/16/2012	Department feedback provided	No
5.0	2/23/2012	Department feedback incorporated	No
6.0	3/23/2012	Additional Department Feedback incorporated	No
6.0	4/9/2012	Additional Department Feedback incorporated	No

Approvals

This document requires the following approvals:

Name	Title
Chris Underwood	MMIS Procurement Project Sponsor
Rob Westphal	MMIS Procurement Project Manager

Distribution

This document has been distributed to:

Name	Title
Rob Westphal	MMIS Procurement Project Manager

Appendix B - Business Capability Matrix (BCM) – CMS Format

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability	"To Be" Level of Business Capability
Member Management	Eligibility Division	ME Determine Eligibility	Determine Client Eligibility	Level 2	Level 3
		ME Enroll Member	Enroll Medicaid Client	Level 1	Level 2
			Enroll CHP+ Client	Level 1	Level 2
		ME Disenroll Member	Disenroll Client	Level 2	Level 3
		ME Inquire Member Eligibility	Inquire Client Eligibility	Level 2	Level 3
		ME Manage Member Information	Manage Client Information	Level 1	Level 2
		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	Manage Client Appeal	Level 1	Level 2
Member Management	Managed Care	Determine Eligibility	Determine Eligibility	Level 2	Level 3
		Enroll Member	Enroll Client	Level 2	Level 3
		Disenroll Member	Disenroll Client	Level 2	Level 2
Provider Management	Provider Services	PM Enroll Provider	Enroll Provider	Level 1	Level 3

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability	"To Be" Level of Business Capability
		PM Disenroll Provider	Disenroll Provider	Level 1	Level 3
		PM Manage Provider Information	Manage Provider Information	Level 1	Level 3
		PM Inquire Provider Information	Inquire Provider Information	Level 2	Level 3
		PM Manage Provider Communication	Manage Provider Relations	Level 2	Level 3
		PM Manager Provider Grievance and Appeal	Manage Provider Grievance and Appeal	Level 1	Level 2
		PM Perform Provider Outreach	Perform Provider Outreach	Level 1	Level 2
Provider Management	Managed Care	Enroll Provider	Enroll Provider	Level 1	Level 2
Contractor Management	Purchasing and Contracting Services	CM Manage Administrative/Health Services Contract	Manage Contract	Level 2	Level 3
		CM Award Administrative/Health Services Contract	Award Contract	Level 1	Level 1
		CM Close-out Administrative/Health Services Contract	Close-out Contract	Level 1	Level 1
		CM Produce Administrative/Health Services RFP	Produce RFP	Level 1	Level 1
	Contract Management	CM Manage Contractor Information	Manage Contractor Information	Level 1	Level 2
		CM Inquire Contractor Information	Inquire Contractor Information	Level 1	Level 2
		CM Perform Potential	Perform Potential	Level 2	Level 2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability	"To Be" Level of Business Capability
		Contractor Outreach	Contractor Outreach		
		CM Manage Contractor Communication	Manage Contractor Communication	Level 1	Level 2
		CM Support Contractor Grievance and Appeal	Support Contractor Grievance and Appeal	Level 1	Level 2
Contractor Management	Managed Care	Award Administrative/Health Services Contract	Award Contract	Level 1	Level 1
		Manage Administrative/Health Services Contract	Manage Contract	Level 1	Level 2
Operations Management	Agency Administration and Operations	OM Authorize Referral	Prior Authorization	Level 1	Level 2
		OM Authorize Service	Prior Authorization	Level 1	Level 2
		OM Authorize Treatment Plan	Define Benefit Packages	Level 1	Level 2
		OM Apply Claim Attachment	Apply Claim Attachment	Level 1	Level 2
		OM Apply Mass Adjustment	Apply Mass Adjustment	Level 1	Level 2
		OM Edit, Audit, Price Claim/Encounter	Audit Claim/Encounter	Level 2	Level 3
		OM Prepare Remittance Advice/Encounter Report	Prepare Remittance Advice/Encounter Report	Level 2	Level 3
		OM Prepare COB	N/A	Colorado does not preform this business process	
		OM Prepare EOB	Prepare EOMB	Level 1	Level 2
		OM Prepare HCBS Payment	Prepare HCBS Payment	Level 2	Level 3
		OM Prepare Provider	Prepare Provider EFT	Level 2	Level 2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability	"To Be" Level of Business Capability
		EFT/Check			
		OM Prepare Premium EFT/Check	Prepare Premium EFT/Check	Level 2	Level 2
		OM Prepare Health Insurance Premium Payment	Prepare HIBI Payment	Level 1	Level 2
		OM Prepare Medicare Premium Payment	Medicare Buy-in Process	Level 2	Level 3
		OM Prepare Capitation Premium Payment	Prepare Capitation Premium Payment	Level 2	Level 3
		OM Manage Payment Information	Manage Payment Information	Level 1	Level 2
		OM Inquire Payment Status	Inquire Payment Status	Level 2	Level 3
		OM Calculate Spend-Down Amount	Calculate Spend-Down Amount	Colorado does not perform this business process	
		OM Prepare Member Premium Invoice	Prepare Member Premium Invoice	Level 1	Level 2
		OM Manage Recoupment	Manage Recoupment	Level 1	Level 2
		OM Manage Estate Recovery	Manage Estate Recovery	Level 1	Level 2
		OM Manage TPL Recovery	Manage TPL Recovery	Level 1	Level 2
		OM Manage Drug Rebate	Manage Drug Rebate	Level 2	Level 3
		OM Manage Settlement	Manage Cost Settlement	Level 1	Level 2
Operations Management	Managed Care	Prepare Capitation and Premium Payment	Prepare Capitation and Premium Payment	Level 2	Level 3
		Manage Payment Information	Manage Changes & Reconcile Capitated Payment Information	Level 1	Level 2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability	"To Be" Level of Business Capability
		Prepare Member Premium Invoice	Member Payment Management	Level 1	Level 2
Program Management	Program/Policy Management	PG Designate Approved Service/Drug Formulary	Designate Approved Service Formulary	Level 1	Level 3
			Designate Approved Drug Formulary	Level 1	Level 3
		PG Manage Rate Setting	Manage Rate Setting	Level 1	Level 3
		PG Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	Level 1	Level 3
		PG Manage Federal Financial Participation for MMIS	Manage FFP	Level 1	Level 2
		PG Formulate Budget	Manage Budget	Level 1	Level 2
		PG Manage State Funds	Manage State Funds	Level 1	Level 2
		PG Draw and Report FFP	Draw and Report FFP	Level 1	Level 2
		PG Manage F-MAP	Manage F-MAP	Level 1	Level 2
		PG Manage 1099s	Manage 1099s	Level 1	Level 2
		PG Perform Accounting Functions	Accounting	Level 1	Level 2
		PG Develop and Maintain Program Policy	Develop and Maintain Program Policy	Level 1	Level 2
		PG Maintain State Plan	Maintain State Plan	Level 1	Level 2
		PG Develop Agency Goals and Objectives	Develop Agency Goals and Objectives	Level 1	Level 2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability	"To Be" Level of Business Capability
		PG Develop and Manage Performance Measures and Reporting	Develop and Manage Performance Measures and Reporting	Level 1	Level 2
		PG Monitor Performance and Business Activity	Monitor Performance and Business Activity	Level 1	Level 3
		PG Manage Program Information	Manage Program Information	Level 1	Level 2
		PG Maintain Benefits Reference Information	Maintain Benefits Reference Information	Level 1	Level 2
		PG Generate Financial and Program Analysis Report	Generate Financial and Program Analysis Report	Level 2	Level 3
Program Management	Managed Care	Manage Rate Setting	Rate Setting	Level 1	Level 3
		Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	Level 1	Level 3
		Accounting	Accounting	Level 1	Level 2
Program Integrity Management	Program Integrity	PI Identify Candidate Case	Identify Candidate Case	Level 1	Level 2
		PI Manage Case	Manage Case	Level 1	Level 3
Business Relationship Management	Legal/Purchasing and Contracting	BR Establish Business Relationship	Establish Business Relationship	Level 1	Level 2
		BR Terminate Business Relationship	Terminate Business Relationship	Level 1	Level 2
		BR Manage Business Relationship	Manage Business Relationship	Level 1	Level 3
		BR Manage Business Relationship Communication	Manage Business Relationship Communication	No current process	Level 2

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability	"To Be" Level of Business Capability
Care Management	Client Services	CM Manage Medicaid Population Health	Manage Medicaid Population Health	Level 1	Level 3
		CM Establish Case	Establish Case	Level 1	Level 3
		CM Manage Case	Manage Case	Level 1	Level 3
		CM Manage Registry	Manage Registry	Level 1	Level 2

Appendix C – Use Case Participants

Colorado MITA Use Case Participants by Division

Name	Division
Bonnie Kelly	Audits & Compliance Division
Nancy Downes	Audits & Compliance Division
Tom Leahey	Audits & Compliance Division
Annie Lee	Benefits and Policy Division
Emily Blanford	Benefits and Policy Division
Guin Blodgette	Benefits and Policy Division
Joey Gallegos	Benefits and Policy Division
Richard Delaney	Benefits and Policy Division: Benefit Policy
Jen St. Peter	Budget Division
Shane Mofford	Budget Division
Carol Reinboldt	Claims System & Operations Division
Carol Shuford	Claims System & Operations Division
Carolyn Segalini	Claims System & Operations Division
Dan Rodriguez	Claims System & Operations Division
Dee Cole	Claims System & Operations Division
Diane Zandin	Claims System & Operations Division
Greg Donlin	Claims System & Operations Division
Jay Puhler	Claims System & Operations Division
Jenny Nunemacher	Claims System & Operations Division
Joan Welch	Claims System & Operations Division
Joanne Svenningsen	Claims System & Operations Division
John Aldag	Claims System & Operations Division
Karen Janulewicz	Claims System & Operations Division
Laurie Stephens	Claims System & Operations Division
Lynn Clinton	Claims System & Operations Division
Nathan Culkin	Claims System & Operations Division
Nellie Pon	Claims System & Operations Division
Paula Ring	Claims System & Operations Division
Sandra Salus	Claims System & Operations Division
Sarah Henderson	Claims System & Operations Division
Shirley Jones	Claims System & Operations Division
Steve Hunter	Claims System & Operations Division
Tanya Chaffee	Claims System & Operations Division
Vernae Roquemore	Claims System & Operations Division

Name	Division
Vicki Foreman	Claims System & Operations Division
Yoseph Daniel	Claims System & Operations Division
Barbara Cosby	Client Services Division
Gina Robinson	Client Services Division
Jeff Konrade-Helm	Client Services Division
Megan Wood	Client Services Division
Jeanine Draut	Compliance for CHP & Medicaid
Cindi Mason	Controller Division
Greg Tanner	Controller Division
Juanita Pacheco	Controller Division
Taylor Larsen	Data Analysis
Parrish Steinbrecher	Division Director
Antoinette Taranto	Eligibility Division
Marivel Guadarrama	Eligibility Division
Tammy Costello	Eligibility Division
Barb Prehmus	Legal Division
David Smith	Legal Division
Erika Bol	Legal Division
Eugenia Renfro	Legal Division
Sharon Brydon	Legal Division
Amy Scangarella	Long Term Care Benefits Division
Casey Dills	Long Term Care Benefits Division
John Barry	Long Term Care Benefits Division
Lois Jacobs	Long Term Care Benefits Division
Nicholas Clark	Long Term Care Benefits Division
Nora Brahe	Long Term Care Benefits Division
Sean Bryan	Long Term Care Benefits Division
Tim Cortez	Long Term Care Benefits Division
Tyler Dienes	Long Term Care Benefits Division
Alan S. Kislowitz	Medical & CHP+ Managed Care & Contracts Division
Bill Heller	Medical & CHP+ Managed Care & Contracts Division
Greg Trollan	Medical & CHP+ Managed Care & Contracts Division
Matt Ullrich	Medical & CHP+ Managed Care & Contracts Division
Teresa Craig	Medical & CHP+ Managed Care & Contracts Division
Chris Acker	Policy
Challon Winer	Purchasing & Contracting Services Section
Cindy Ward	Purchasing & Contracting Services Section
Kerri Coffey	Purchasing & Contracting Services Section
Angela (Chris) Ukoha	Quality & Health Improvement
Anna Davis	Quality & Health Improvement

Name	Division
Jerry Ware	Quality & Health Improvement
Jim Leonard	Quality & Health Improvement
Katie Brookler	Quality & Health Improvement
Katie Mortenson	Quality & Health Improvement
Lisa Waugh	Quality & Health Improvement
Sonia Sandoval	Quality & Health Improvement
Vince Sherry	Quality & Health Improvement
Russ Kennedy	Quality/Health Improvement
Aniss Sahli	Rates & Analysis Division
Anne Martin	Rates & Analysis Division
Beth Martin	Rates & Analysis Division
Bret Pittenger	Rates & Analysis Division
Byron Burton	Rates & Analysis Division
Jeremy Tipton	Rates & Analysis Division
Joel Dalzell	Rates & Analysis Division
Jon Meredith	Rates & Analysis Division
Kara Ann Donovan	Rates & Analysis Division
Marguerite Richardson	Rates & Analysis Division
Michael Sajovetz	Rates & Analysis Division
René Horton	Rates & Analysis Division
Sarah Campbell	Rates & Analysis Division
Sean-Casey King	Rates & Analysis Division
Sharon Liu	Rates & Analysis Division
Julie Collins	Strategic Performance
Jerry Smallwood	Medicaid Reform Unit

Appendix D – Use Cases

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Determine Eligibility
Author(s): *Tanya Chaffee, Steve Hunter, Carol Shuford, Jon Meredith, Lois Jacobs, Sean Bryan, Casey Dills, Aniss Sahli, Byron Burton, Gregory Donlin, Rene Horton, Shirley Jones, Sarah Campbell, Megan Wood, Tammy Costello, Marivel Guadarrama, Lynn Clinton, Dan Rodriguez, Vernae Roquemore, Joey Gallegos*	
Facilitator: *Kassie Gram*	
Actor: *CBMS, TRAILS, Eligibility workers (counties, DHS, MA sites and PE sites), operational contractor (Deloitte), OIT (data center and business process owner for CBMS), eligibility division at the Department (business requirements owner), CMS (Coordination of Benefits for dual eligible and Medicare buy-in), CHP+ RCCO, MAXIMUS – Enrollment Broker, Case Management Agencies*	
Description: *The **Determine Eligibility** business process receives and stores member eligibility information* *Eligibility is determined using CBMS, a shared system, used by the Department/DHS* *MMIS functions as the payment system* *CBMS functions as system of record for eligibility (for non-foster care clients)* *TRAILS functions as the system of eligibility for foster care*	
Precondition: *New enrollment or redetermination*	
***Trigger*:** • Original eligibility application data set • On-going case maintenance (EDBC) • SSI feed (for clients who are automatically eligible) • Scheduled Event: Time for Redetermination	
Manual (M) or Automated (A) **1. M/A** **2. A** **3. M/A**	***Steps*:** 1. Start: **Receive** eligibility application data 2. **Assign** Case Number 3. **Verify** status of application (new, on-going, or redetermination) 4. **Validate** syntax and semantic requirements associated with eligibility

4. M/A **5. M/A** **6. M/A** **7. A** **8. A** **9. A** **10. A (CBMS)** **11. A** **12. A** **13. A**	application a. Business rules identify fatal and non-fatal errors and associated error messages 5. **Validate** completeness and required fields a. Business rules identify mandated fields and apply edits 6. **Verify** eligibility documentation for disability, pregnancy, applicant resources, etc. 7. **Run** Eligibility Determination Benefit Calculation (EDBC) and **apply** composite eligibility determination rules — summation of all rules determines if applicant is eligible or not, and if eligible, for which category of eligibility 8. **Assign** eligibility category (ies) 9. **Assign** State Medicaid I.D. 10. **Request** that the ***Manage Applicant and Member Communication*** process generate notifications 11. **Load** eligibility information from the eligibility interface into MMIS 12. **Assign** eligibility type 13. **Associate** benefit packages a. Documented State-specific rules on which eligible categories map to which benefit packages and services. I.e. do benefit packages include Managed Care? Some are optional.
***Outcome*:** • Eligibility is determined	
Shared Data/Interfaces: • TRAILS (system of record for foster care) determines eligibility for the foster care system and merges with CBMS records and inputs into MMIS • Benefits Utilization System (BUS) (CBMS) (shared data, manual process) • SVES SCHIP • IEVS Wage • SDX • BENDEX • PARIS • NDNH • SOLQ-I • SVES • MMIS • DSS • CMS • CCART	

- Mental Health Database
- Eligibility Inquiry Tools (i.e., Web Portal, faxback, AVERS)

To Be:

- Send pended and denied records from CBMS to MMIS
- Centralized access to all information relating to review and approval of PARs
- Bi-directional communication from MMIS to CBMS
- Electronic application submission
- Interface with state and national validation sources to identify fraud, waste and abuse (vital statistics, IRS, corrections)
- Solve privacy issues with data sharing to allow for comprehensive data interfaces (as indicated above)
- Interface with address correction/update service to obtain up-to-date client contact information so client communications can be successfully completed; enable clients to update contact information on-line

Failures:

- Current system does not have a centralized location for all PAR reviewers to have access to eligibility and benefit package information
- Delay in a decision, backdating eligibility
- Delay in a decision, load letter not accepted by provider
- The Department must translate CMBS information outside of either system into legacy MMIS values
- Inaccurate eligibility data: client retroactively ineligible and eligibility in CBMS. While not supposed to happen unless they are put a new case, once the eligibility span is eliminated, there was nothing to send to MMIS to update the span
- MMIS data edits must be done manually in CBMS; with multiple players making it difficult to correct data in a timely manner
- Updated record from CBMS replaces data in MMIS
- Managing data in two systems with one way feed creates data integrity issues
- Human error
- No access to vital statistics and similar data sources to automatically validate/populate data
- Difficult or impossible to locate/contact clients who have moved

Notes: *No notes captured.*

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Enroll Member
Author(s): Tanya Chaffee, Steve Hunter, Carol Shuford, Jon Meredith, Lois Jacobs, Sean Bryan, Casey Dills, Aniss Sahli, Byron Burton, Gregory Donlin, Rene Horton, Shirley Jones, Sarah Campbell, Megan Wood, Tammy Costello, Marivel Guadarrama, Lynn Clinton, Dan Rodriguez, Vernae Roquemore, Joey Gallegos	
Facilitator: Kassie Gram	
***Actor*:** CBMS, MMIS, PDCS, DSS, BUS, Department staff, TRAILS	
Description: The ***Enroll Member*** business process is responsible for managing clients' enrollment in benefits determination, including – gathering information into the system. Linking of benefit package to the program. This process excludes Managed Care.	
Precondition: Eligibility data has been received for authorized clients	
***Trigger*:** Eligibility file that may accompany initial or redetermination of eligibility	
Manual (M) or Automated (A) **1. A** **2. A** **3. A** **4. A** **5. A**	***Steps*:** 1. Start: **Receive** member eligibility data from the ***Determine Eligibility*** process 2. **Process** eligibility data required for benefit package determination 3. **Generate** request that enrollment information be loaded into MMIS 4. **MMIS assigns** benefits for Medical claims and Pharmacy claims 5. End: **Notify** PDCS for pharmacy claims NOTE: Managed Care Enrollment is described under the Managed Care Business Use Case
***Outcome*:** Client is assigned to benefit package and notified of enrollment	
Shared Data/Interfaces: • PDCS • MMIS • DSS	

- Long Term Care group (looks at information)
- CBMS
- TRAILS
- Web Portal
- Other eligibility tools required for inquiries

To Be:

- Notify eligibility determination systems (BUS, CBMS, TRAILS) of benefit enrollment
- Electronic communication to the client (i.e., text for baby); real-time care management
- Flexible MMIS and DSS
- Interface with national validation sources to identify fraud, waste and abuse (vital statistics, IRS, corrections)
- Centralized access to all information to generate client communication: reduce redundancies and confusing information
- Multi-language function
- Interface with address and telephone correction/update service to obtain up-to-date client contact information so client communications can be successfully completed; enable clients to update contact information on-line

Failures:

- When assigning eligibility type in MMIS, if required CBMS data values conflict (or not provided) MMIS assigns Eligibility Type of '999'; preventing the client from being enrolled in the correct benefit package
- No process for notifying and reconciling errors identified by MMIS error reports within CBMS
- Required fields missing or not correct — Request additional or corrected information from Client or ***Determine Eligibility*** process
- EOMB are sent to the wrong clients, or contains wrong information (I.e. eligibility spans, demographic information, etc.)
- Human error
- Antiquated MMIS system; doesn't allow for implementation of new rules or validation to assure proper demographics
- Difficult or impossible to locate/contact clients who have moved

Notes: *No notes captured.*

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Disenroll Member
Author(s): Nora Brahe, Carol Shuford, Paula Ring, Laurie Stephens, Katie Mortenson, Jerry Ware, Jon Meredith, Joey Gallegos, Lisa Waugh, René Horton, Diane Stayton	
Facilitator: Kassie Gram	
***Actor*:** Counties, MA Sites, Eligibility Sites, State staff, clients, SEPS (single entry point – LTC case management agencies), MMIS, Program Performance, Fiscal Agent, CHP+ Enrollment Broker	
Description: The ***Disenroll Member*** business process is responsible for managing the termination of a client's enrollment in a program, including processing eligibility terminations and requests for disenrollment. Requests can be: • Submitted by a client, program provider or contractor • Death, failure to meet enrollment criteria due to change in health or financial status, or change in residency Note: Counties, MA Sites, Eligibility Sites may perform some of the steps in this process.	
Precondition(s): • Application received • Enrolled client	
***Trigger(s)*:** • Death • Client request • Change in financial situation • Change in residence • Change in function • Change in age	
Manual (M) or Automated (A) **1. M** **2. M**	***Steps*:** **LTC:** 1. Start: **Perform** functional assessment

3. A **4. A** **5. A**	2. **Determine** change in function and eligibility information 3. **Enter** information in BUS and send to CBMS 4. **Pass** information through interface from CBMS to MMIS (eligibility file) 5. End: **Load** information into MMIS
1. M **2. A** **3. A**	**Change in Eligibility Information:** 1. Start: **Enter** new information in CBMS and/or TRAILS 2. **Pass** information through the interface from CBMS to MMIS (eligibility file) 3. End: **Load** information into MMIS
1. M **2. M** **3. M**	**Manual Client disenrollment:** 1. Start: **Locate** Client information in the MMIS 2. **Update** necessary information in the MMIS to reflect appropriate action 3. Disenrollment information is **saved** in the MMIS

***Outcome*:**

Member is disenrolled and previous MMIS eligibility status is overwritten in MMIS

Shared Data/Interfaces:

- MMIS
- DSS
- BUS
- CBMS
- Files shared with CMS
- CGI
- CMS
- COBC
- TRAILS

To Be:

- Need audit trail in MMIS
- Save history in MMIS
- Ability to reconcile data discrepancies between MMIS and CBMS – don't overlay/delete if information is different. Write old information to a table before updating with new information
- 2-way interface between CBMS and MMIS
- Workflow management for information entry in CBMS (to ensure MMIS gets data in needs)
- Help function/tutorial within MMIS
- More editing capabilities on the MMIS side
- Data load validation – kick incorrect values to error file for validation, before populating in MMIS

- Improved client education on Medicaid redetermination process
- MMIS shall allow manual enrolment/disenrollment as required
- Implement a flexible system that allows Managed Care enrollment specialist to assign Foster Care Clients as needed (with appropriate justification)

Failures:

- No audit trail due to overwriting of eligibility status in MMIS from CBMS
- Incorrect values received from CBMS are loaded into MMIS without validation
- 999 enrollment spans are invalid, however, because of a system error, the 999 code does not allow a user to update the Client record as desired (for Medicaid only). For some reason, CHP+ has not problem updating the Client enrollment/disenrollment with these 999 enrollment spans
- MMIS does not allow Foster Care Clients to be assigned to a primary physician
- Clients that are active in TRAILS and CBMS, the CBMS data is not transmitted to MMIS, thus losing critical data

Notes:

It is understood that when clients fill out an eligibility applications using PEAK, the request goes to Maximus and someone from Maximus manually enters the client's information into CBMS. Maximus also manually enters CHP client data into CBMS.

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Inquire Member Eligibility
Author(s): Nora Brahe, Carol Shuford, Paula Ring, Laurie Stephens, Katie Mortenson, Jerry Ware, Jon Meredith, Joey Gallegos, Lisa Waugh, René Horton	
Facilitator: Kassie Gram	
***Actor*:** Providers, Health Plans, CBMS, TRAILS, counties, State staff, web portal, Fiscal Agent, MMIS, DSS, CMERS, Fax Back, MA Site, CHP+ Enrollment Broker	
Description: The ***Inquire Member Eligibility*** business process receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; prepares and sends the appropriate information to the requestor. This information exchange is meant to indicate whether the client is eligible for some health benefit plan coverage under Medicaid and/or CHP+, in accordance with HIPAA. In some cases, this information exchange may include more detailed information about the Medicaid programs, specific benefits and services, and the provider(s) from which the client may receive covered services. NOTE: For this discussion, we are not including Client requests for eligibility verification.	
Precondition: Need for eligibility verification	
***Trigger*:** • Request for services • Request for eligibility	
Manual (M) or Automated (A)	***Steps*:**
1. M **2. M** **3. M**	1. Start: State staff or Fiscal Agent **receives** request for eligibility verification 2. **Search** MMIS for client eligibility, if authorized 3. End: **Response** provided
	Alternate Sequence – Automated request through Web Portal, CMERS, or Fax Back
1. M **2. A**	1. Start: **Request** eligibility verification 2. End: **Response** returned

***Outcome*:** Eligibility verified
Shared Data/Interfaces: • MMIS • DSS • CBMS • TRAILS • CMERS • Fax Back • Web Portal
To Be: • New eligibility system • New MMIS • New DSS • Consistent eligibility responses across all platforms • Capture retro eligibility and ineligibility • More flexibility in modification of ETL between CBMS and MMIS and between MMIS and DSS • Data load validation (testing/staging environment) – kick incorrect values to error file for validation, before populating in MMIS
Failures: • Human error • Misinterpretation through web portal • Inconsistent eligibility responses from different systems may cause confusion • TRAILS does not capture or send TPL or Medicare data to MMIS, thereby giving incomplete or inaccurate information on the presence or absence of primary payers to providers.
Notes: *No notes captured.*

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Manage Member Information
Author(s): Nora Brahe, Carol Shuford, Paula Ring, Laurie Stephens, Katie Mortenson, Jerry Ware, Jon Meredith, Joey Gallegos, Lisa Waugh, René Horton	
Facilitator: Kassie Gram	
***Actor*:** Client, MMIS, CBMS, BUS, SEPs, TRAILS, State staff, Fiscal Agent, PAR vendor, CHP+ Vendor (Enrollment Broker)	
Description: The ***Manage Member Information*** business process is responsible for adding, deleting and modifying all client Medicaid information from the Medicaid data store (MMIS). This process considers how the Medicaid enterprise creates and updates the "source of truth" for client demographic, financial, socio-economic (LTC), and health status information (LTC). **NOTE:** This also covers MMIS validating data upload requests, applying instructions, and tracking activity. Client data includes: • All eligibility and enrollment spans • Administration of benefits from multiple programs • Historical applications and determination data and program enrollment/disenrollment • Covered services (including historical) • All communication, outreach and EOBs • Client grievance/appeal records • Records or pointers to any services requested and services provided	
Precondition: Enrolled client	
***Trigger*:** • Receive updated client information from client, provider, or eligibility assistance site • Required SEP monitoring activities • Service provided and claim submitted • PAR requests • LTC client reassessments • RRR – Redetermination/Recertification/Reassessment • Receipt of client grievance or appeal	

Manual (M) or Automated (A)	***Steps*:**
	Receive Update Client Information:
1. M	1. Start: **Receive** data change/update
2. M	2. **Enter** new information in CBMS
3. A	3. **Pass** information through interface from CBMS to MMIS
4. A	4. End: **Load** information into MMIS
	SEP Monitoring and LTC Client reassessment:
1. M	1. Start: SEP **enters** data into BUS
2. A	2. BUS **passes** information to CBMS
3. A	3. **Pass** information through interface from CBMS to MMIS
4. A	4. End: **Load** information into MMIS
	Claims:
1. M/A	1. Start: Provider **submits** claim for service to MMIS
2. A	2. **Process** claim through edits
3. A	3. End: **Load** claim information into MMIS
	PAR Requests:
1. M	1. Start: Provider **submits** request to reviewing agencies
2. M	2. Reviewing agencies **enters** request into MMIS
3. M	3. Request is **approved** or **denied**
4. M	4. Approval/Denial **entered** in MMIS
5. A	5. End: **Load** information into MMIS
	RRR: (Redetermination/Recertification/Reassessment)
1. A	1. Start: **Send** automated RRR to client
2. M	2. Client **returns** completed form
3. M	3. **Enter** updated information into CBMS
4. A	4. **Pass** information through interface from CBMS to MMIS
5. A	5. End: **Load** information into MMIS
	Grievance and Appeal:
1. M	1. Start: **Receive** grievance or appeal
2. M	2. End: **Track** appeals in Access database
***Outcome*:** Client information is updated and maintained.	

Shared Data/Interfaces:

- CBMS
- MMIS
- DSS
- BUS
- TRAILS

To Be:

- Collect health status information for all clients – mandatory field, with option to not respond
- More accurate way to collect client demographics and socio-economic information - mandatory field, with option to not respond
- Standardized demographic options (i.e. race/ethnicity fields consistent with U.S. Census Bureau options)
- Ability to accept EHR information into MMIS
- Require entry of health status information
- NEW DSS
- New BUS
- Expand to multi-languages
- Want option for electronic or mail communication with client
- Communication should be language and literacy appropriate
- Standardized demographic options (i.e. race/ethnicity fields consistent with U.S. Census Bureau options)

Failures:

- No ability for multi-language access – especially Spanish
- Clients don't receive and/or understand the request to provide updated information
- Difficult or impossible to locate/contact clients who have moved or changed telephone numbers

Notes: *No notes captured.*

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Perform Population and Member Outreach
Author(s): Nora Brahe, Carol Shuford, Paula Ring, Laurie Stephens, Katie Mortenson, Jerry Ware, Jon Meredith, Joey Gallegos, Lisa Waugh, René Horton	
Facilitator: Kassie Gram	
***Actor*:** Clients, prospective clients, State staff, outreach contractor, training contractor, providers, eligibility workers, nationwide data contractor, CHP+ Vendor (Enrollment Broker)	
Description: The ***Perform Population and Member Outreach*** process targets both prospective and current Client populations for distribution of information about programs, policies, and health issues. For example: • New benefit packages and population health initiatives • New initiatives from Program Administration • Training • Medicaid program education • Information on other programs that may be available to a client (i.e. EPSDT and/or CHIP)	
Precondition: Enrolled in or eligible for Medicaid or CHP+	
***Trigger*:** • Client assessed as having a need for a specific service • Client expansion initiatives • Health initiatives/promotions • Policy changes • Process improvement • Problem identified with current process • Benefit expansion initiatives • Health promotion to existing population	

Manual (M) or Automated (A)	*Steps*:
	Individual Client Specific:
1. M	1. Start: **Inform** client about service and how it matches their need
2. M	2. End: **Provide** information about service delivery
	Group Clients Specific:
1. M	1. Start: **Obtain** stakeholder input
2. M	2. **Target** areas/groups are identified
3. M	3. **Determine** most effective way to provide information
4. M	4. **Generate** outreach list from DSS, if applicable
***5.* M**	5. End: **Provide** the information
	Prospective Clients:
1. M	1. Start: **Obtain** stakeholder input
2. M	2. **Target** areas/groups are identified
3. M	3. **Determine** most effective way to provide information
4. M	4. **Determine** area of state with high eligible, but not enrolled, population
***5.* M**	5. End: **Provide** the information

***Outcome*:**

- Increased enrollment
- Increased appropriate benefit utilization
- Improved health outcomes
- Improved health literacy
- Improved client engagement

Shared Data/Interfaces:

- MMIS
- DSS
- Stakeholder Access databases
- CBMS

To Be:

- Sort by a variety of variables in the DSS
- Improved reporting capabilities in the DSS
- Single stakeholder database
- Targeted and appropriate communications with clients

- Interface with address and telephone correction/update service to obtain up-to-date client contact information so client communications can be successfully completed; enable clients to update contact information online

Failures:

- Coordination between State agencies and within State agencies
- Stakeholder management and engagement
- Inability to identify the right clients (have bad contact information); difficult or impossible to locate/contact clients who have moved or changed telephone numbers
- Inability to address population health - identification of sub-groups
- Lack of cultural competency

Notes:

It is understood that when clients fill out an eligibility applications using PEAK, the request goes to Maximus and someone from Maximus manually enters the client's information into CBMS. Maximus also manually enters CHP client data into CBMS.

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Manage Applicant and Member Communication
Author(s): Nora Brahe, Carol Shuford, Paula Ring, Laurie Stephens, Katie Mortenson, Jerry Ware, Jon Meredith, Joey Gallegos, Lisa Waugh, René Horton	
Facilitator: Kassie Gram	
***Actor*:** Clients, prospective clients, applicants, eligibility workers, State staff, ID card contractor, OAC, CBMS, MMIS, DSS, Health Plans, SEPs, BUS	
Description: The ***Manage Applicant and Member Communication*** business process handles requests for information, appointments, and assistance from prospective and current clients. This process includes **inbound inquiries** and **outbound responses** related to: • Eligibility redetermination, benefits, providers • Health plans and programs • Scheduled communications such as Medicaid ID cards, redetermination notifications • Notifications regarding grievances and appeals (includes both the receipt of grievance/appeal notification, as well as, the outbound communication of decision)	
Precondition: Need for information	
***Trigger*:** • Request for information regarding eligibility – lost ID card, program information, denied prior authorization request • Scheduled communications – RRR, Medicaid ID cards, LTC reauthorization, Notice of Action	
Manual (M) or Automated (A) **1. M** **2. M** **1. M/A** **2. M** **3. M**	***Steps*:** **Request for Information:** 1. Start: **Receive** request for information 2. End: **Provide** information **System Generated Communications – RRR and Notice of Action:** 1. Start: **Send** RRR packet to client 2. Client **returns** completed forms 3. End: **Enter** updated information in CBMS

1. M **2. A** **3. A** **4. M** **5. A** **6. M/A**	**Scheduled Communications – Medicaid ID Cards:** 1. Start: **Enroll** client 2. **Write** client is to the Medicaid ID card request file from CBMS 3. **Send** file is to State staff through interface 4. State staff **manually manipulates** data in file 5. **Send** file to the ID card contractor 6. End: ID card contractor **prints** and **mails** ID cards to clients
1. M **2. M** **3. M** **4. M** **5. M** **6. M**	**LTC Reauthorization Communication:** 1. Start: SEP case manager **tracks** LTC functional eligibility date spans 2. SEP case manager **initiates** outreach efforts to re-evaluate continuing functional need within 90 days of the certification end date 3. SEP case manager **determines** functional eligibility 4. SEP case manager **communicates** outcome communicated County income maintenance technician 5. County income maintenance technician **updates** the Benefits Utilization System (BUS) 6. End: Notice of Action is **sent** to the client

***Outcome*:**

- Information provided
- Clients able to obtain services

Shared Data/Interfaces:

- MMIS
- DSS
- CBMS
- TRAILS
- Contractor ftp site
- BUS

To Be:

- No manual manipulation of any files
- Addresses for all clients, not just head of household
- Client should be able to check enrollment status online
- Auto-generated notices sent at milestones during enrollment processes
- Eliminate duplicate notifications to clients

- Make paper communication optional
- Interface with address correction/update service to obtain up-to-date client contact information so client communications can be successfully completed; enable clients to update contact information on-line
- Easily identify all members of a family; capability of linking mothers and babies

Failures:

- Address information is only collected for head of household
- Timeliness of notifications
- Difficult or impossible to locate/contact clients who have moved or changed telephone numbers

Notes: *No notes captured.*

MEMBER MANAGEMENT USE CASE	
***Business Area*:** Member Management	***Business Process:*** Manage Member Grievance and Appeal
Author(s): Casey Dills O'Donnell, Vernae Roquemore, Jon Meredith, Joey Gallegos	
Facilitator: Kassie Gram	
***Actor*:** BUS, MMIS, Department staff, Office of Appeals staff, Client or their advocate, Case Managers, Contractors (including Fiscal Agent)	
Description: The ***Manage Member Grievance and Appeal*** business process handles applicant or client (or their advocate's) appeals of adverse decisions or communications of a grievance. For example: • How a grievance/appeal is logged and tracked • How a grievance/appeal is triaged to appropriate reviewers • How a grievance/appeal is researched • How and when a grievance/appeal hearing is deemed necessary; and what happens? Including how results of the hearing are documented and distributed	
Precondition: • Adverse action occurs • Client or applicant has filed application or intent to file an application has been determined	
***Trigger*:** • Client or applicant files appeal • Client or applicant verbalizes the intent to file an appeal to appropriate agencies	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M**	***Steps*:** 1. Start: **Receive** written or verbal notification of appeal 2. **Submit** formal appeal to Office of Administrative Courts 3. Office of Administrative Courts **notifies** the Office of Appeals regarding formal appeal 4. Office of Appeals **tracks** and **distributes** appeal to appropriate policy staff 5. Assigned policy staff or designee **tracks**, **researches**, **participates** and

8. M	**files** paperwork and attends hearings as necessary 6. **Receive** Final Agency Decision (FAD) 7. Eligibility information is **updated** as necessary per decision (FAD) a. LTC updates the BUS/CBMS which is fed forward to MMIS b. Fee For Service updates MMIS 8. **Refresh/re-run** eligibility

***Outcome*:** Grievance and appeal process has been completed

Shared Data/Interfaces:

- CBMS
- Contractors (including Fiscal Agent)
- MMIS
- BUS
- Access database
- Excel spreadsheets

To Be:

- One Prior Authorization reviewing agency
- Centralized repository for all agencies/departments to utilize
- Automate appeal notices
- Electronic appeals submission
- Electronic notification of appeals and appeal rights
- Standardization of communication to reduce confusion that causes appeals
- Multi-language capability
- Multi-grade level capability
- Interface with address correction/update service to obtain up-to-date client contact information so client communications can be successfully completed; enable clients to update contact information on-line

Failures:

- Manual process
- Multiple players managing their own repositories (tracking, research, etc.)
- Multiple vendors reviewing Prior Authorization request, creating inconsistencies
- Lack of client outreach on appeal process/appeal rights
- Communication is confusing to clients
- Difficult or impossible to locate/contact clients who have moved or changed telephone numbers

Notes: *No notes captured.*

PROVIDER MANAGEMENT USE CASE	
***Business Area*:** Provider Management	***Business Process:*** Enroll Provider
Author(s): Karen Janulewicz, Laurie Stephens, John Aldag, Chris Acker, Jeff Konrade-Helm, Jon Meredith, Nicholas Clark, Rene Horton, Angela (Chris) Ukoha, Tanya Chaffee, Byron Burton, Joel Dalzell	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Fiscal Agent, Providers, State staff, Enrollment Specialist, Medicaid Policy Specialist, Contract Managers, MMIS, TPMS, DHS	
Description: The ***Enroll Provider*** business process is responsible for managing providers' enrollment in programs, including – gathering information into the system. External contractors such as quality assurance and credentialing verification services may perform some of these steps.	
Precondition: New enrollment	
***Trigger*:** <u>State-transition Trigger Events</u> - Receipt of the following from either the provider or external contractor: 1. Enrollment application data set containing provider name, provider address, provider affiliation, provider SSN or EIN, provider type, specialty, taxonomy, allowed services, provider credentials or licenses, etc. 2. Modification or cancellation of an application data set 3. Additional information in support of an enrollment application <u>Environmental Trigger Event</u> - Receipt of scheduled prompt of user request to: 1. Periodic verification of credentials for practitioners a. Monitor sanctions. If sanction has been applied to MCD for enrollment process b. Assist in program integrity review	
Manual (M) or Automated (A) **1. M**	***Steps*:** 1. Start: **Receive** enrollment application 2. **Validate** application [If validation fails, process terminates – see Failures]

2. M **3. M** **4. A** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M** **12. A** **13. M**	3. **Determine** submission status by querying the MMIS (initial, resubmitted with modification, or duplicate) [If duplicate, process terminates and result messages are produced – see Failures] 4. **Assign** Medicaid ID 5. **Enter** application information into MMIS 6. **Determine** applicant type/provider taxonomy: e.g., primary, rendering, pay to, billing, other 7. **Assess** enrollment type to determine appropriate required verification 8. **Verify** information on the enrollment application or record with internal and external sources, including enumerators, sanction status, credentials. 9. Fiscal Agent **Approves** application if no State approval is needed 10. **Determine** State approval and rates, if required: Includes identifying type of rate, e.g., negotiated, Medicare, percent of charges, case management fee, other via look-ups in the reference and benefit repositories 11. **Submit** and communicate approved/denied status via transmittal for State reviewed applications 12. End: **Send** approval or denial letter to the provider (***Manage Provider Communication***) 13. Optional: **On-going** information is available for providers on the Department's external website
Alternate Sequence: **1. M** **2. M** **3. M**	Alternate sequence: 1. **Approve** Medicaid provider 2. **Review** ACC or PCP application if submitted 3. **Execute** contract for ACC or PCP

***Outcome*:**

- The Provider is enrolled or denied
- The MMIS is updated, enrollment data required for operations is made available, and alerts are broadcast to providers
- The Provider is notified about enrollment results

Shared Data/Interfaces:

- TPMS – manual & automated
- COFRS - manual
- Web portal - manual & automated
- DORA - manual on initial enrollment
- National Plan and Provider Enumeration System (NPPES) - manual process
- OIG
- OSCAR database – manual on enrollment

- LEIE
- ASPEN – DPHE – manual process
- SAVE verification – manual process
- Medical Quest (Peregrine) (find a provider on state website)

To Be:

- Reevaluate enrollment based on, e.g., performance measures, or triggered by date such as anniversary date based on Medicaid policy to verify data based on a contractual duration e.g. year or months
- Provider enrollment information updated back to TPMS and DPHE (to update web portal & notify DPHE of enrollment status)
- ACC and PCP provider enrollment process in MMIS
- Tax identifiers, legal name, and dba are verified in State Controllers Office; want to have this information verified with the IRS at enrollment in MMIS
- Online enrollment for providers, including zip code validation
- Some degree of automation
- National sharing database
- Require providers to update information through web portal
- Require providers to update / confirm address and other contact information at least annually via web portal
- Family Health Coordinators need access to the web portal or Medical Quest should be updated
- Need a way to qualify providers – allowing new clients, existing clients, specific age groups, languages, services – this information should be accessible to Family Health Coordinators
- Enroll providers based on NPI rather than using legacy provider IDs

Failures:

Process Failure: Enrollment application processing terminates or suspends due to:

- Duplicate applications
- Lost or missing information due to human error
- The responsibility for determining provider type requirements has moved from one department to another (some institutional knowledge has been lost)
- 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) 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
- Family Health Coordinators don't have access to which providers are enrolled Medicaid providers, and are not notified when a new provider is enrolled
- Provider contact information outdated / incorrect

Notes: *No notes captured.*

PROVIDER MANAGEMENT USE CASE	
***Business Area*:** Provider Management	***Business Process:*** Disenroll Provider
Author(s): Karen Janulewicz, Laurie Stephens, John Aldag, Chris Acker, Jeff Konrade-Helm, Jon Meredith, Nicholas Clark, Rene Horton, Angela (Chris) Ukoha, Tanya Chaffee, Byron Burton, Joel Dalzell	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Providers, MMIS, Fiscal Agent, Department staff, DHS	
Description: The ***Disenroll Provider*** business process is responsible for managing disenrollment in the Medicaid program. This business process covers the processing of disenrollment including the tracking of disenrollment requests and validation that that the disenrollment meets State's rules.	
Precondition: Enrolled provider	
Trigger*:** Receipt of a disenrollment request, or modification or cancellation of a request, along with associated data, e.g., reason for disenrollment, effective date: Requested by the provider Requested by another Business Process, e.g., the ***Manage Provider Communication, ***Monitor Performance and Business Activities***, and Program Integrity, ***Manage Case*** processes – Due to receipt of information about a provider's death, retirement, or disability from the ***Manage Provider Communication*** or ***Manage Provider Information*** processes	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M**	***Steps*:** 1. Start: **Receive** disenrollment request from provider 2. **Determine** if provider type requires State approval for disenrollment 3. If yes, **see** alternate sequence option 4. **Contact** provider to **verify** termination request 5. **Determine** if provider had any paid claims after requested date of termination 6. If yes, **contact** provider regarding paid claim. The provider will have the option to reimburse the Department or change the requested date of termination to 1 day after date of paid claim 7. **Determine** if provider has an outstanding AR balance with Department 8. **Submit** provider disenrollment request to ACS with spreadsheet (includes:

Alternate Sequence: **1. M** **2. M** **3. M** **4. M** **5. M**	provider number, termination date) 9. **Enter** termination information to internal spreadsheet. This spreadsheet tracks the termination reason, which is not tracked in MMIS 10. ACS **completes** termination 11. End: **Verify** that termination was completed in MMIS Alternate Sequence: 1. State staff **generates** Disenrollment request 2. **Request** termination by Fiscal Agent through transmittal 3. **Determine** if provider had any paid claims after requested date of termination 4. If yes, **contact** provider regarding paid claim. The provider will have the option to reimburse the Department or change the requested date of termination to 1 day after date of paid claim 5. **Determine** if provider has an outstanding AR balance with Department
***Outcome*:** Provider is terminated	
Shared Data/Interfaces: N/A	
To Be: • Share termination data with Public Health, TPMS, web portal, and provider database contractor • Automate letter to notify provider of both involuntary and voluntary termination • Capture termination reason in MMIS • Allow provider to self-disenroll and remove from web portal	
Failures: Disenrollment processing terminates due to: • Human error • Lost data	
Notes: *No notes captured.*	

PROVIDER MANAGEMENT USE CASE	
***Business Area*:** Provider Management	***Business Process:*** Manage Provider Information
Author(s): Laurie Stephens, Jay Puhler, Jeff Konrade-Helm, Sonia Sandoval, Sandy Salus, Nicholas Clark, Dee Cole, Richard Delaney, Tanya Chaffee, Vernae Roquemore, Rene Horton, Nathan Culkin, Jon Meredith, Lisa Waugh, Marguerite Richardson, Emily Blanford, John Aldag	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Fiscal Agent, Web Portal, State staff, providers, DSS, MMIS, TPMS	
Description: The ***Manage Provider Information*** business process is responsible for managing all operational aspects of the MMIS, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid program.	
Precondition: Written information from provider or department. Receipt of application or correspondence from prospective or current provider.	
***Trigger(s)*:** • Receipt of application or written information • Correspondence from provider in form of mail or phone call • Entry or update of information on web portal • Receipt of transmittal from state. Returned correspondence (via mail) • External data feeds for excluded status, licensure validation • Provider Background results	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M**	***Steps*:** 1. Start: **Receipt** of documentation by the Fiscal Agent 2. **Verify** documentation for accuracy and completion 3. **Update** entered into MMIS 4. Fiscal Agent **enters** updates to MMIS, except when State approval required 5. If State approval required, fiscal agent **sends** to appropriate person at State for approval 6. **Review** completed by state

Alternate Sequence: **1. M** **2. M** **3. A**	7. End: **Notify** Fiscal Agent of approval via transmittal Alternate Sequence: Web Portal 1. Start: **Enter** updates directly into the web portal (only if provider is eligible to make the update) 2. Authorized provider **submits** updates 3. End: Interface **updates** MMIS within 24 hours
***Outcome*:** MMIS is updated with current provider information.	
Shared Data/Interfaces: • Web Portal Interface – manual & automated • State Controllers Office (COFRS) – currently manual • MMIS • Trackwise • DSS • State Share • ASPEN – DPHE – manual process • TPMS – manual & automated • DORA - manual on initial enrollment • National Plan and Provider Enumeration System (NPPES) - manual process • OIG • OSCAR database – manual on enrollment • LEIE • Validation of Zip Code (and/or entire address) with external interface	
To Be: • Paperless • Interface with ASPEN to cross reference providers • Interface with DORA • Interface with all accreditation agencies • Interface with NLR (National Level Repository) • Ability to accept electronic signature • Ability to accept electronic documents • Interface with vital statistics • Interface with Internal Revenue Service • Interface with CMS • Audit capabilities	

- Have provider ALERTS that give notice of pending CLIA, facility or professional license expiration.
- Validate location addresses against UPS, FedEx, Mailboxes R Us and other post office box addresses. Any matching location address would result in denial of application to enroll.
- Require providers to update / confirm address and other contact information at least annually via web portal
- Include tables to store all required provider disclosures: Ownership/relationship of owners, Managing Employees, Significant Transactions, Affiliations with other provider IDs.
- Have capability to query and pull reports of all provider disclosure information.
- Have capability to enroll in-home caregivers and managed care network providers.
- Provider information should have separate fields for last name, first name, middle name or initial, and credentials. There is a huge need to be able to pull this information in separate columns for background checking and affiliation analysis.
- All claims should use license status to price claims. When licenses expire, all claims are to deny until provider submits updates to licensure status.

Failures:

- Mail
- Human error (delay and inaccuracy)
- Inability to record multiple address types (billing vs. physical address(es)), (CLIA)
- Current system does not use license status to price and pay claims. We are paying providers who are no longer licensed
- Provider names are inconsistently input into MMIS, which makes it nearly impossible to parse the names into Last Name, First Name, Middle Name/Initial, and Credentials
- Changes to Provider name/address in MMIS does not update COFRS; resulting in a disconnect between communications sent from MMIS and payment sent from COFRS

Notes: *No notes captured.*

PROVIDER MANAGEMENT USE CASE	
***Business Area*:** Provider Management	***Business Process:*** Inquire Provider Information
Author(s): Laurie Stephens, Jay Puhler, Jeff Konrade-Helm, Sonia Sandoval, Sandy Salus, Nicholas Clark, Dee Cole, Richard Delaney, Tanya Chaffee, Vernae Roquemore, Rene Horton, Nathan Culkin, Jon Meredith, Lisa Waugh, Marguerite Richardson, Emily Blanford, John Aldag	
Facilitator: Rhonda Brinkoeter	
***Actor*:** PCP, client, provider, Fiscal Agent, state staff, case managers, Web Portal, contractors	
Description: The ***Inquire Provider Information*** business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry.	
Precondition: Identified need for a service	
***Trigger*:** Receipt of a request for provider enrollment verification	
Manual (M) or Automated (A) **1. M** **2. M** **1. M** ***2.* A**	***Steps*:** 1. Start: **Receive** request for verification via phone call to the State (NOTE: if the Fiscal Agent is contacted, they will only provide verification with valid provider number) 2. End: **Respond** to request for verification Alternate Sequence: Web Portal or Medical Quest or NPPES 1. Start: **Submit** inquiry for provider enrollment verification 2. End: **Receive** response
***Outcome*:** Verification response received	
Shared Data/Interfaces: • Web Portal • Medical Quest • NPPES • MMIS • DSS	

To Be: • Ability to search by provider type in MMIS • Ability to search providers by language capability • Multilingual search capabilities • Provider directory generation capabilities
Failures: • Incorrect or out of date data • Not all provider types loaded on web portal provider look up mechanism • Human error
Notes: *No notes captured.*

PROVIDER MANAGEMENT USE CASE	
***Business Area*:** Provider Management	***Business Process:*** Manage Provider Communication
Author(s): Laurie Stephens, Jay Puhler, Jeff Konrade-Helm, Sonia Sandoval, Sandy Salus, Nicholas Clark, Dee Cole, Richard Delaney, Tanya Chaffee, Vernae Roquemore, Rene Horton, Nathan Culkin, Jon Meredith, Lisa Waugh, Marguerite Richardson, Emily Blanford, John Aldag	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Fiscal Agent, State staff, providers, Web Portal	
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. This includes scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. Outreach information to enrolled providers may relate to corrections in billing practices, provider complaints, public health alerts, public service announcements, retention efforts, drive to sign up more Primary Care Physicians, and changes in the Medicaid program policies and procedures.	
Precondition: Enrolled providers	
***Trigger*:** • Program changes (rates, forms, etc.) • Support and education • Notifications of non-payment (from COFRS) • PARs • Notification of termination for no claims	
Manual (M) or Automated (A) **1. M/A** **2. M/A** **3. M/A**	***Steps*:** 1. Start: **Send** pre-approved request to Fiscal Agent Operations section as necessary. 2. Request **received** by authorized State staff or designee for distribution as appropriate

	3. End: **Distribute** information

***Outcome*:**

Appropriate information is communicated to providers.

Shared Data/Interfaces:

- Web portal
- Website
- MMIS
- DSS
- Email

To Be:

- Support multiple provider email addresses
- Email address verification/validation
- Ability to unsubscribe
- Logging and tracking of communications
- Targeted communications (audience and timing)
- Filtered search capabilities
- Return receipt capabilities
- Provider subscription options
- Require providers to update / confirm address and other contact information at least annually via web portal

Failures:

- System limitations
- Inability to customize communications
- Outdated email system
- Contract limitations
- Incorrect provider contact information

Notes: *No notes captured.*

PROVIDER MANAGEMENT USE CASE	
***Business Area*:** Provider Management	***Business Process*:** Manage Provider Grievance and Appeal
Author(s): Laurie Stephens, Jay Puhler, Jeff Konrade-Helm, Sonia Sandoval, Sandy Salus, Nicholas Clark, Dee Cole, Richard Delaney, Tanya Chaffee, Vernae Roquemore, Rene Horton, Nathan Culkin, Jon Meredith, Lisa Waugh, Marguerite Richardson, Emily Blanford, John Aldag	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Providers, State staff, Attorney General Office (AG), Office of Administrative Courts (OAC), contractors, Fiscal Agent, interfaces (see below)	
Description: The ***Manage Provider Grievance and Appeal*** business process handles provider, both prospective and current, appeals of adverse decisions. An 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 file.	
Precondition: Enrolled or pending provider enrollment	
***Trigger*:** Adverse action has occurred (denied enrollment, denied payment, terminated enrollment, etc.)	
Manual (M) or Automated (A) **First Sequence:** **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M**	***Steps*:** First Sequence: Appeal leads to a hearing 1. Start: Provider **submits** written provider appeal to OAC within required time 2. **Forward** written appeal request to AG's office 3. AG's office **notifies** provider and Department about receipt of appeal, via written notification from the AG's office 4. Department **conducts** research on the reported issue 5. Department **provides** recommendation to the AG's office 6. AG's office **determines** whether to proceed with a hearing or recommend dismissal to provider 7. Dismissal **occurs** or AG's office **schedules** hearing within required time 8. AG's office **conducts** hearing to reach a decision 9. AG's office **updates** the case file for historical reference

	10. Provider and Department **receive** notification of decision
***Outcome*:** Resolution of appeal	
Shared Data/Interfaces: • DORA • NPPES • ASPEN • OIT • MMIS • DSS	
To Be: • Capabilities to track appeals communication, notifications, etc. • Improved interface with DORA • Comprehensive database of nation-wide provider information • Ability to access correct information (rule, address, etc.)	
Failures: • Incorrect regulation(s) • Lack of time to gather data • Too many players • Researching proper Rules updates is time consuming	
Notes: *No notes captured.*	

PROVIDER MANAGEMENT USE CASE	
***Business Area*:** Provider Management	***Business Process:*** Perform Provider Outreach
Author(s): Laurie Stephens, Jay Puhler, Jeff Konrade-Helm, Sonia Sandoval, Sandy Salus, Nicholas Clark, Dee Cole, Richard Delaney, Tanya Chaffee, Vernae Roquemore, Rene Horton, Nathan Culkin, Jon Meredith, Lisa Waugh, Marguerite Richardson, Emily Blanford, John Aldag	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Fiscal Agent, State staff, providers, contractors, clients	
Description: The ***Perform Provider Outreach*** business process originates internally within the State Medicaid program in response to various activities. Outreach materials may be distributed through various media. The production and distribution are tracked and the materials are archived according to State archive rules. Outreach information to prospective providers may be 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) Outreach information to enrolled providers may relate to retention efforts, drive to sign up more Primary Care Physicians, and changes in the Medicaid program policies and procedures.	
Precondition: Prospective or enrolled providers	
Trigger: Scenarios include: Not enough providers to serve a population, new immigrants that need language-compatible providers, corrections in billing practices, provider complaints, public health alerts, public service announcements, retention efforts, drive to sign up more Primary Care Physicians, and changes in the Medicaid program policies and procedures.	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M**	***Steps*:** First Sequence: Prospective Provider Outreach 1. Start: **Conduct** gap analysis 2. **Identify** prospective providers 3. **Contact** prospective providers

5. M **6. M** **Alternate Sequence:** **1. M** **2. M** **3. M** **4. M** **5. M**	4. **Send** enrollment/marketing information to prospective providers 5. **Assist** with enrollment if requested 6. End: **Submit** enrollment application, if applicable Alternate Sequence: Retain Providers 1. Start: **Identify** providers 2. **Contact** providers 3. **Send** marketing information to providers 4. **Assist** with enrollment if requested 5. End: **Submit** enrollment application, if applicable

***Outcome*:**

- Providers are enrolled/retained
- Client access needs are met

Shared Data/Interfaces:

- DORA
- MMIS
- DSS
- CDPHE
- Website
- NPPES
- CMS

To Be:

- Improved access to data
    a. Ability to pull provider data at an authorized user level
    b. Ability to pull provider data/reports by specialty, claims history, changes in claims history, (for example, identify existing providers whose claim activity significantly decreases or increases, stops or starts), provider status, etc.
    c. Ability to pull reports by virtually any populated field on provider screens
    d. Ability to flag accounts for system generated alerts
    e. Ability to easily identify providers with high rates of denied claims (perhaps by number or paid/denied ratio, etc.) to identify providers in need of additional training or support
    f. Ability to do wild card searches for all searchable fields, including searches with partial ID numbers, etc.

Failures: • New process
Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contract or Management	***Business Process:*** Manage Contract
Author(s): Lynn Clinton, Vicki Foreman, Emily Blanford, Amy Scangarella, Sean Bryan, Jon Meredith, Katie Brookler, Cindy Ward	
Facilitator: Jennifer Kraft	
***Actor*:** Contract managers, Claims Systems (system changes) and Operations (fiscal agent), Contract Management System	
Description: The ***Manage Administrative or Health Services Contract*** business process receives the contract award, implements contract monitoring procedures, and updates the contract if needed, and continues to monitor the terms of the contract throughout its duration.	
Precondition: • Kick off meeting • Transition period (on new vendor or new contract) • Contract execution	
***Trigger(s)*:** Protest period expires	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M/A** (reports) **5. M** **6. M** **7. M** **8. M**	***Steps*:** 1. Start: **Conduct** initial contractor meeting (review deliverables, timelines, responsibilities between State and Contractor) 2. (Optional) **Conduct** kick off meeting (for executive leadership) 3. **Monitor** contract deliverables, due dates, feedback on deliverables, understand contractor processes, facilitate contractor payment 4. **Monitor** contract and manage performance using the following: a. QHI staff **monitors** Accountable Care Collaborative Initiative: Covers Managed Care and RCCO performance management i. Quarterly Report trends on enrollment/disenrollment ii. Report Client grievances and appeals (determination/denial/changes in services) iii. Report network adequacy b. QHI staff **conducts** annual compliance review i. **Conduct** site visits,

	ii. **Review** membership book management iii. **Analyze** trends iv. **Review** utilization c. QHI staff **conducts** annual performance measure validations i. QHI staff, in conjunction with contractors and Contract Managers, establish performance measures ii. Managed Care contractor or Data Analyst staff obtains actual data related to the performance measure iii. QHI staff and Data Analyst review actual versus expected iv. An External Quality Review Organization (EQRO) utilizes standard protocol to review contractor performance v. EQRO conducts analysis and submits a report of findings vi. Department staff review findings and determine if additional action is required d. QHI staff **evaluates** and **monitors** Performance Improvement Projects (PIP): i. Managed Care Contractor establishes at least two active PIPs ii. QHI staff reviews appropriateness of program, including data related to efficacy of services provided, and provides feedback as necessary e. QHI staff monitors client experience of care. Contractor information is combined with FFS information so that the Department can evaluate experience of care for the entire Medicaid program (waiver services are excluded) 5. Results of reviews/validations are **distributed** as necessary a. If positive, findings are communicated b. If out of compliance, corrective action is required i. Activity to be performed is identified ii. Completion of activity is assessed iii. If incomplete, QHI staff determine appropriate action 6. **Manage** contract changes: amendments, renewals (i.e., cost, quantity, tasks) 7. **Execute** amendment/changes 8. End: **Start** RFP process again
***Outcome*:** • Successful services are provided • Compensation is paid by contractor	

Shared Data/Interfaces:

- Depends on contract (i.e., general MMIS, and its subsystems, interfaces between State and contractor)
- State share
- Trackwise
- SharePoint
- Department Community Board notices
- Department Website information

To Be:

- Automated reports
- Notifications for timing (tickler file, milestones, deliverables)
- Notification of reporting requirements, approvals
- Document management
- Notification of when contract term ends (start process for RFP)
- Standardize notification system for internal use (department-wide tickler system)
- Automate waivered contracts
- Combined Department system searchable by office, division and section
- Monitoring – increase ability to communicate positive performance
- Contractor/admin payments captured in MMIS???

Failures:

- Staff member leaves (contract manager)
- Lose funding or reduced funding for contract

Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contractor Management	***Business Process:*** Award Contract
Author(s): Lynn Clinton, Vicki Foreman, Emily Blanford, Amy Scangarella, Sean Bryan, Jon Meredith, Katie Brookler, Cindy Ward	
Facilitator: Jennifer Kraft	
***Actor*:** Contract Manager, Purchasing Director, Purchasing Division, Stakeholder Managers (depending on area), Evaluation Team	
Description: The ***Award an Administrative or Health Services Contract*** business process utilizes requirements, advanced planning documents, requests for information, requests for proposal and sole source documents. This process is used to request and receive proposals, verifies proposal content against RFP or sole source requirements, applies evaluation criteria, designates contractor/vendor, posts award information, reviews and renders decisions on protests, negotiates contract, and notifies parties. In some States, this business process may be used to make a recommendation of award instead of the award itself.	
Precondition: RFP is posted to BIDS.	
***Trigger*:** • Receive proposal or approval for Sole Source • Purchase Order (no proposal required)	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M/A** **8. M** **9. M** **10. M**	***Steps*:** 1. Start: **Receive** proposal(s) 2. **Establish** evaluation team and scoring criteria 3. Purchasing department **reviews** eligibility 4. Evaluation Team **evaluates** proposals 5. Evaluation Team **submits** recommendation to Purchasing 6. **Present** intent to award to Department Purchasing Director 7. **Announce** award via BIDS 8. **Allow** 7 business day protest period 9. **Conduct** contract negotiations and finalize Statement of Work 10. End: **Execute** contract

1. **M** 2. **M** 3. **M**	Alternate if Award is protested: 1. State Purchasing designee **receives** contractor's written protest 2. **Review** nature of protest 3. State Purchasing Director or Denver District Court **responds** to contractor within 10 days (copy State Purchasing and Executive Director). Response outlines due process (appeal rights) a. Contractor can appeal the response
***Outcome*:** Service is provided to clients or department	
Shared Data/Interfaces: • Validating References – manual • BIDS	
To Be: • Streamline clearance process • Limit clearance process • Better understand Stakeholders • Better way to identify evaluation committee members; create electronic system that identifies potential committee members by experience. Store committee members information in database for future reference • Implement electronic clearance to receive approvals faster • Streamline/automate evaluation data collection and scoring process • Standard guidance for scoring (i.e. justification of scores)	
Failures: • Unidentified conflicts of interest • No respondents • Ineligible respondents	
Notes: *No notes captured.*	

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contractor Management	***Business Process*:** Close Out Contract
Author(s): Lynn Clinton, Vicki Foreman, Emily Blanford, Amy Scangarella, Sean Bryan, Jon Meredith, Katie Brookler, Cindy Ward	
Facilitator: Jennifer Kraft	
***Actor*:** Contract managers, Claims Systems (system changes) and Operations (fiscal agent), Contract Management System and contractor, legal (pulled in by contract manager), purchasing	
Description: The ***Close-out Administrative or 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 turnover to the new contractor is completed according to contractual obligations.	
Precondition: • Contract term ends • Contract breach / business failure • Loss of funding	
***Trigger(s)*:** • Receive instruction to terminate contract • Notification of loss of funding or business failure • Contract obligations have been fulfilled • Term ends	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M/A** **1. M**	***Steps*:** 1. Start: Contractor to **provide** transition plan (6 months prior for ongoing services) 2. **Verify** contractor has met requirements 3. **Verify** funds payment 4. End: Contract is **closed** Alternative Steps due to breach in contract: 1. Contact Purchasing (and possibly Legal)
***Outcome*:** Contract is closed out	

Shared Data/Interfaces: • None
To Be: • Standardized checklist of contract close-out activities • System/electronic tracking of activity status (e.g. to be completed, completed & date) • Training for close-out process • Standard format for contracts
Failures: • Uncooperative transition • Unexpected contract termination leads to no vendor ready to assume responsibility • No contingency plan • Administrative complexity of procurement/contract/approval process to have successor ready to assume responsibilities from outgoing contractor
Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
Business Area: Contractor Management	***Business Process***: Produce Administrative/Services RFP
Author(s): Challon Winer, Kerri Coffey	
Facilitator: Kassie Gram	
Actor: Program staff, Drafting staff, Purchasing Agent, BIDS, Vendors, Clearance - Leadership Budget staff, Accounting staff, Human Resources staff, Privacy Officer	
Description: The ***Produce Administrative/Health Services RFP*** business process gathers requirements, develops a Request for Proposals (RFP), requests and receives approvals for the RFP, and solicits responses.	
Precondition: Program or function exists	
Trigger: • Anything requiring a new vendor For example: o Contract expiration o New statute, regulation or rule requiring a new vendor o Failing Vendor o New Program	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M** **12. M** **13. M**	***Steps***: 1. Start: Program staff **requests** solicitation 2. Procurement director **approves** and **submits** the request to the drafting unit 3. Drafting unit staff **coordinates** with subject matter experts to draft RFP language and determine requirements 4. Program staff and subject matter experts **review** and **finalize** draft RFP 5. Program staff **coordinates** Clearance process 6. Drafting unit **conducts** final review the approved RFP 7. Drafting unit **delivers** the final RFP to the Purchasing Agent Unit 8. Purchasing Agent **reviews, completes** Evaluation Criteria and **updates** the RFP as necessary 9. Purchasing Agent and Program staff **assemble** the Proposal Evaluation Committee

	10. Purchasing Agent **finalizes** and **posts** RFP to BIDS 11. Purchasing Agent **receives** questions from interested parties and **coordinates** with Program staff to answer questions and/or modify RFP as necessary 12. Purchasing Agent **posts** any RFP modifications and responses to questions to BIDS 13. End: Purchasing Agent **receives** Vendor proposals

***Outcome*:**

- Receipt of vendor proposals
- Failed procurement due to lack of receipt of acceptable proposals

Shared Data/Interfaces:

- BIDS
- Internal shared drive (or email)

To Be:

- Automated and electronic clearance process
- Streamlined concurrent review of documentation (and real-time view of comments)
- Ability to share document status and progress real-time
- Ability to accept proposals via BIDS

Failures:

- Clearance process is time consuming

Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contractor Management	***Business Process*:** Manage Contractor Information
Author: Cindy Ward, Tanya Chaffee, Amy Scangarella, Sandy Salus, Sharon Liu, Chris Acker, René Horton, Jon Meredith, Shirley Jones, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Purchase Orders, Projects and Contracts Databases (3 Access databases), State Contract Staff, State Staff outside of Contract staff (as required), Contractors	
Description: The ***Manage Contractor Information*** business process receives a request for addition, deletion, or change to the existing contract; validates the request, applies the instruction, and tracks the activity.	
Precondition: Contract has been executed.	
***Trigger*:** Receipt of a request for modification to the contract.	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M**	***Steps*:** 1. Start: **Receive** contract modification form 2. Procurement staff **reviews** and works with contract manager to **draft** modification 3. Contract managers **review** and **approve** 4. **Route** modification through clearance process 5. Procurement staff **enters** required information in appropriate databases 6. End: Contract manager **sends** a copy of the modified contract to contractor
***Outcome*:** Contract modification is executed.	
Shared Data/Interfaces: • OIT modifying the Contract Management System (CMS) for Department use • PDCS	

To Be:

- Electronic shared repository for signed contracts
- Search for a signed contract
- Eliminate paper
- Electronic clearance process (SharePoint)
- Ability to version
- Forms are finalized prior to fiscal year (controlled document release)
- Ability to generate reports

Failures:

- No shared drives
- Lack of access
- Versioning issues
- Lost information/folders
- Form changes (mid-process)

Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contractor Management	***Business Process:*** Inquire Contractor Information
Author: Cindy Ward, Tanya Chaffee, Amy Scangarella, Sandy Salus, Sharon Liu, Chris Acker, Rene Horton, Jon Meredith, Shirley Jones, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** State contract staff, Legal, potential vendor	
Description: The ***Inquire Contractor Information*** business process receives requests for contract verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the send outbound transaction process. This is called an Open Records Request in the State of Colorado.	
Precondition: Executed contract	
***Trigger(s)*:** • Receipt of request for contractor verification • Legislative request	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M**	***Steps*:** 1. Start: **Receive** request in writing for verification of contract 2. **Send** request to Legal and contract staff 3. **Prepare** electronic response within 3 days, if possible 4. End: **Send** response to requestor
***Outcome*:** Verification response is sent to requestor.	
Shared Data/Interfaces: • CORA • PDCS	

To Be: • Ability for requestors to electronically request and access contracts
Failures: • Current process is time consuming • Current process is paper intensive • It can be difficult to understand requests
Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contractor Management	***Business Process:*** Perform Contractor Outreach
Author: Cindy Ward, Tanya Chaffee, Amy Scangarella, Sandy Salus, Sharon Liu, Chris Acker, Rene Horton, Jon Meredith, Shirley Jones, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Contractors, State staff	
Description: The ***Perform Contractor Outreach*** business process originates initially within the Medicaid program and are distributed by various medium in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures. The communications may be produced, distributed, tracked, and archived by the agency according to state archive rules. For prospective contractors, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs. For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives.	
Precondition: Executed contract	
***Trigger(s)*:** • Change in policy • Change in fees • Request for report • Request for process improvement • Addressing client or provider complaints • Upcoming legislation (State requests contractor input into process) • Upcoming procurement activities (prospective contractors) • Monthly Provider Bulletin	
Manual (M) or Automated (A) **1. M** **2. M**	***Steps*:** 1. Start: **Send** direct or indirect communication to contractor (electronic or verbal) 2. End: **Address** any feedback received from contractor

***Outcome*:** Information is communicated to contractors.
Shared Data/Interfaces: • BIDS • Website • Contractor FTP sites • BUS • Web Portal • MMIS • DSS • PDCS
To Be: • New BUS • BUS to interface with MMIS • Paperless process • Have State owned secure FTP site (where we an assign contractor log-in information) rather than accessing contractor's FTP site • Consistent protection of PHI • Encrypted electronic delivery of PHI (for large files)
Failures: • Security issues (PHI) • Manual delivery of PHI
Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contractor Management	***Business Process:*** Manage Contractor Communication
Author: Cindy Ward, Tanya Chaffee, Amy Scangarella, Sandy Salus, Melissa McCalmont (Department Observer), Sharon Liu, Chris Acker, Rene Horton, Jon Meredith, Shirley Jones, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Contractor, State staff, MMIS, DSS, Fiscal Agent, CBMS, Legal and Contract staff, Legislative Branch	
Description: The ***Manage Contractor Communication*** business process receives requests for information, appointments, and assistance from contractors 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. Other examples of communications include: - Pay for performance communications – performance measures could effect capitation payments or other reimbursements - Incentives to improve encounter data quality and submission rates	
Precondition: Executed contract	
***Trigger(s)*:** • Request for information from contractor • Requirement in contract	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **Alternate Sequence:**	***Steps*:** 1. Start: **Receive** request for policy information or Department direction from contractor 2. **Research** questions from contractor 3. End: **Respond** to contractor request ***Alternate Sequence*** *– Data (This applies to data requests that are outside the scope of the contract / not already covered by the contract)**:***

1. **A** 1. **M** 2. **M** 3. **M** 4. **M** 5. **M** 6. **M** 7. **M**	1. **Provide** scheduled/calendared data per contract External data request (must be approved/amended contract): 1. Start: **Receive** completed form 2. **Route** to External Data Request (EDR) Board *If Board decides Treatment Payment Operations (TPO),* **approve** request 3. Executive committee **approves** or **vetoes** 4. End: **Distribute** data to contractor *If Board decides against Treatment Payment Operations (TPO) request:* 5. **Determine** request response in the best interest of clients 6. Executive committee **approves** or **vetoes** 7. End: **Communicate** decision to contractor
***Outcome*:** Response is communicated to contractor	
Shared Data/Interfaces: • MMIS • DSS • CBMS • BUS • EDR • Department website • Locally stored flat files • PDCS	
To Be: • New BUS • BUS to interface with MMIS • BUS to interface with CBMS • Interface with CMS Managed Care System (PACE) • No solid media (disks or paper) • Have our own secure FTP site (where we an assign contractor log-in information) rather than accessing contractor's FTP site • Consistent protection of PHI • Encrypted electronic delivery of PHI (large file) • All reporting and data will include DSS information and reporting is automated (with contractor having secure data access that pertains to their information only) – role based	

- Financial management capability for budgeting and accounting purposes
- Utilization tracking and forecasting for Program management
    - Includes both program and client utilization management
    - Cost containment and identification of actionable items within all programs
- Automated and flexible reporting for federal, state and contract requirements. May include giving limited secure access to select contractors
- Ability to link either physically or virtually to other data sources. (Think vital stats, APCD, HER, etc.)
- Measures internal to the data warehouse; quality assurance, speed or response time, improvements or the time to make them, etc. (think measures of successful data warehousing)
- DSS automated reporting to CMS

Failures:

- Security issues (PHI)
- Manual delivery of PHI
- Reporting that happens out of production environment
- Communication delays
- Lack of automation
- Human error

Notes: *No notes captured.*

CONTRACTOR MANAGEMENT USE CASE	
***Business Area*:** Contractor Management	***Business Process:*** Support Contractor Grievance and Appeal
Author: Cindy Ward, Tanya Chaffee, Amy Scangarella, Sandy Salus, Sharon Liu, Chris Acker, Rene Horton, Jon Meredith, Shirley Jones, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor*:** Prospective contractors, contractors, State staff, State procurement, Attorney General (AG), Medical Services Board	
Description: The ***Support Contractor Grievance and Appeal*** business process handles contractor appeals of adverse decisions or communications of a grievance. Once received, 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. This process supports the ***Program 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:** 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.	
Precondition: Contract awarded	
***Trigger(s)*:** • Prospective contractor files a protest • Contractor appeals a policy decision or audit finding	
Manual (M) or Automated (A) **1. M** **2. M** **3. M**	***Steps*:** **Protest:** 1. Start: Prospective contractor **files** written protest within 7 days of date of award

4. M	2. State **responds** to protest within 10 days *If prospective contactor **files** an appeal with State purchasing director or Denver District Court:* 3. Appropriate party **makes decision** about protest 4. End: **Send** response to prospective contractor
	Policy and rule changes:
1. M	1. Start: **Communicate** new or changed policy to contractor
2. M	2. Contractor **responds** with concern
3. M	3. Contractor **contacts** Executive Director
4. M	4. Medical Services Board may need to **review** the issue
5. M	5. End: **Communicate** decision to contractor
	Audit Finding:
1. M	1. Start: **Communicate** audit finding to contractor
2. M	2. Contractor **appeals** or **asks** for reconsideration
3. M	3. Department **considers** new evidence
4. M	4. End: Department **makes decision** and **communicates** to contractor

***Outcome*:** Department responds to contractor concern or prospective contractor protest.

Shared Data/Interfaces:

- BIDS (prospective contractor)
- BUS
- CBMS
- PDCS

To Be:

- Standardized/formal process
- Shared database to track appeals and audit findings

Failures:

- No standardized or formal process in place

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Authorize Treatment Plan
Author(s): Katie Mortenson, Russ Kennedy, Emily Blanford, Vernae Roquemore, Carol Reinboldt, Jon Meredith, René Horton, Joanne Svenningsen, Michael Sajovetz, Sean Bryan	
Facilitator: Kassie Gram	
***Actor*:** Case Management Agency, Provider, Client, Family member, Social Services (Case Manager), ULTC 100.2 (uniform long term care eligibility data), Fiscal Agent, County Eligibility Technician, Department staff (High-level review and approval when required)	
Description: The ***Authorize Treatment Plan*** process is used to assess a client's needs, decide on a course of treatment, and create treatment plans comprised of providers, provider types, and services.	
Precondition: Indication of Long Term Care (LTC) need	
***Trigger*:** Referral to Case Management Agency	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M/A (A- depending on agency)** **6. M/A** ***Some PARS are electronically and some manually*** **1. M** **2. M** **3. M** **4. M** ***5.* M**	***Steps:*** 1. **Start: Receive** request/inquiry 2. Case Management Agency **determines/verifies** eligibility and level of need 3. Case Management Agency **creates** and **authorizes** (or seeks Department approval for) a Treatment Plan 4. Case Management Agency **loads** Treatment Plan into Benefits Utilization System (BUS) 5. Case Management Agency **submits** a PAR to the Fiscal Agent 6. End: Fiscal Agent **enters** PAR into the MMIS ***Steps for LTC Nursing facilities:*** 1. Start: **Receive** request/inquiry 2. Case Management Agency **determines/verifies** eligibility and level of need 3. Nursing Facility **creates** Treatment Plan 4. Nursing Facility **submits** 5615 to authorizing agency 5. Authorizing Agency **delivers** PAR to Fiscal Agent – (Automated) 320 byte proprietary transaction

***Outcome*:**

- Authorized Treatment Plan
- Client receives appropriate services in appropriate amount, scope and duration
- Provider receives appropriate payment

Shared Data/Interfaces:

- BUS
- MMIS
- CCMS-PA (DD)
- 5615
- ULTC 100.2
- PASRR Results (Pre-Admission Screening and Resident Review – feeds into the treatment plan)
- CBMS
- PAR forms

To Be:

- MMIS integration with Case Management database (replace the BUS)
- Bi-directional integration of MMIS with Eligibility Determination Systems
- Interface with Vital Stats
- All transactions to be HIPAA compliant (remove proprietary and paper based PAR transactions)
- Ability to accept all (electronic) attachments
- Better coordination between case management agency and county
- Conflict free case management
- Standardization of transactions, with the ability to edit appropriately
- Better reporting data (i.e. for authorization service vs. used services)
- Audit support
- Electronic revision of PARS
- Improved client needs/functional assessment tool (ULTC 100.2)

Failures:

- Extended Timelines to authorize PARs and treatment plans
- Human error associated with paper-based PAR transactions
- BUS and MMIS communication is only one-way (no MMIS→BUS feedback loop)
- Too many PAR revisions – would like a better way of managing PARS
- PAR number changes with revision
- Delayed confirmation/verification of financial eligibility causing delays in the provision of necessary services

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Authorize Referral
Author(s): Katie Mortenson, Russ Kennedy, Emily Blanford, Vernae Roquemore, Carol Reinboldt, Jon Meredith, René Horton, Joanne Svenningsen, Michael Sajovetz, Sean Bryan	
Facilitator: Kassie Gram	
***Actor*:** Provider, Client, and Specialist	
Description: The ***Authorize Referral*** process is used when referrals between providers must be approved for payment, based on state policy. Examples are - referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment.	
Precondition: If client is in Fee for Service Medicaid and enrolled in ACC, PCP, or COUP then they must have referral to specialist. If client is enrolled in managed care or BHO then all services are managed through that managed care entity.	
***Trigger*:** Client presents with a need for a service that requires a referral	
Manual (M) or Automated (A) **1. M/A** **2. M** **3. M** **4. M**	***Steps*:** 1. **Start: Receive** request for referral 2. **Schedule** appointment with Specialist 3. **Request** confirmation of referral from ACC, PCP or COUP is made by the Specialist 4. **End: Receive** Medicaid number from ACC, PCP, or COUP for the Specialist to include with billing statements
***Outcome*:** • Service can be provided • Specialist can be reimbursed	

Shared Data/Interfaces:

- MMIS
- CGI Web Portal
- PDCS (pharmacy)
- DSS

To Be:

- Interface that allows electronic confirmation of referrals
- Improved referral confirmation number (currently the PCP provider's ID)
- Link originating provider to specialist they are referring
- Care coordination repository
- Improve client monitoring and outcomes
- Editing/auditing on other provider numbers that come in on claims (e.g., NPI for all provider fields)

Failures:

- No ability to edit
- Inconsistent claims adjudication on referrals (e.g., claims don't deny without referral)
- No ability to audit
- Lack of accurate provider status (e.g., no longer eligible)
- Non-compliant clients (e.g., don't want PCP)

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Authorize Service
Author(s): Katie Mortenson, Russ Kennedy, Emily Blanford, Vernae Roquemore, Carol Reinboldt, Jon Meredith, René Horton, Joanne Svenningsen, Michael Sajovetz, Sean Bryan	
Facilitator: Kassie Gram	
***Actor*:** Providers, clients, authorizing agents (external to Department), Department staff (cost containment), Utilization manager	
Description: The ***Authorize Service*** process focuses on both pre and post authorization of specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment.	
Precondition: • Client presents with a need for a service that requires authorization • Level of need identified	
***Trigger*:** • Request is submitted	
Manual (M) or Automated (A) **1. M/A** **2. M/A** **3. M/A** **4. A** 1-3 reviewing agency determines M or A, depends on service	***Steps*:** 1. Start: **Receive** initial or revised request (PAR) 2. **Review** of PAR by the authorizing agency to ensure it meets established criteria 3. **Submit** PAR and PAR decision by the authorizing agency 4. End: **Generate** letter to provide client and provider the PAR decision
***Outcome*:** Client is approved/denied to receive services.	

Shared Data/Interfaces:

- BUS
- MMIS
- CCMS-PA (DD)
- 5615
- ULTC 100.2
- CBMS
- PAR forms
- CarewebQI
- CGI Web Portal
- DSS

To Be:

- Everything to be electronic; eliminate paper
- No manual processes
- Direct (electronic) interfaces between ALL authorizing vendors and MMIS
- Real-time information
- Auto PAR approval
- Single sign-on for providers
- All PARs submitted through a web interface
- Centralized access to all information relating to review and approval of PARs
- Real-time emergency department authorizations similar to systems used in private sector
- MMIS / DSS tracking of real-time ED authorizations

Failures:

- Too many applications to sign into
- Too much paper
- Too much manual intervention
- Too many vendors
- ED services not PAR-ed similar to private sector

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Claim/Encounter Processing (covers Edit/Audit and Pricing of Claims)
Author(s): Joan Welch, Nellie Pon, Sandy Salus, John Aldag, Vernae Roquemore, Sarah Campbell, Sharon Liu, Nathan Culkin, René Horton, Jon Meredith, Carol Reinboldt	
Facilitator: Kassie Gram	
***Actor(s)*:** Department staff, Fiscal Agent, Providers or claims submitters, Managed Care Organizations, MMIS, DSS, COFRS, CBMS, DORA, Credentialing Organizations, CMS, Other State Agencies	

Description:

Processing claims and encounters, this includes editing, auditing and pricing claims.

The ***Edit Claim/Encounter*** receives original or adjustment claim/encounter data and:

- Determines its submission status
- Validates edits, service coverage, TPL, coding
- Populates the data set with pricing information

The ***Audit Claim-Encounter*** business process receives a validated original or adjustment claim/encounter data and checks:

- Payment history for duplicate processed claims/encounters and lifetime or other limits
- Services requiring authorization have approval, clinical appropriateness, and payment integrity
- Suspends fee for service claims data that fail audits for internal review, corrections, or additional information.

The ***Price Claim-Value Encounter*** business process applies pricing algorithms to claims/encounters and ensures that all adjudication events are documented. Examples include calculating fee for service, managed care, and Accountable Care Capitations (ACC), calculating and applying member contributions (patient payment and co-pays), DRG, provider advances, liens and recoupment.

Precondition:

- Service claims/encounters have been submitted
- Service claims/encounters need to be reimbursed
- Claim accepted for processing
- Rules around submitting a claim have been established
- Rate is set and client is enrolled
- Adjudication data is loaded and available

• Edits and edits dispositions are defined • Client copay requirements / applicability defined	
***Trigger(s)*:** • Claim/Encounter is submitted • Capitation cycle • Receipt of transmittals (to adjust claims)	
Manual (M) or Automated (A) **1. M/A** **2. M/A** **3. M/A** **a. M/A** **b. M/A** **4. M/A** **5. M/A** **a. A** **b. A** **c. A** **d. M** **e. M** **6. M/A** **a. M/A** **b. A** **c. A** **7. M/A** **a. M** **b. A** **c. A** **8. A**	***Steps*:** 1. Start: **Receipt** of request a. Claims can be received electronically or paper b. Encounters are only received electronically 2. **Validate** minimum required information is present for claim/encounter to be entered into the system 3. **Edit** the claim/encounter a. If necessary, **edit** data provided on the claim/encounter to match valid system data (e.g., client and provider and other claim data) b. **Perform** business edits as necessary to match valid claim/encounter criteria (e.g., service submitted on the claim matches policy rules, provider type, authorizations, etc.) 4. **Review** and **validate** appropriate claim/encounter information is present and ready for pricing 5. **Price** the claim/encounter according to the pricing hierarchy: a. Fee schedule b. Rates (e.g., hospital, ASC grouper, provider-specific, procedure modifier, managed care rates, etc.) c. Client-specific prior authorization pricing d. Manual pricing as necessary (e.g., invoices, multiple surgeries, appeals, transmittals, etc.) e. BHO or Mental Health encounters only – price the flat file encounters using MCO provider-specific rates 6. **Audit** the claim/encounter a. **Check** for duplicate processed claims/encounters b. A**pply** benefit limitations if applicable c. **Check** for contraindications 7. **Conduct** final pricing activities for the claim/encounter a. If a BHO or Mental Health encounter, Claims Processing staff **adjusts** the payment/pricing based on: i. Third Party Liability payments b. If an encounter other than BHO or Mental Health, the MMIS

	adjusts the payment/pricing based on: i. Client co-payments ii. Third Party Liability and Medicare payments iii. Client payments iv. Apply prior authorization and other cut back pricing c. If a claim, the MMIS **adjusts** the payment/pricing for: i. Client co-payments ii. Third Party Liability and Medicare payments iii. Client payments iv. Apply prior authorization and other cut back pricing v. Deduct any applicable accounts receivable amounts (due to the financial cycle) 8. End: Claim/encounter adjudication results are **recorded**

***Outcome*:**

- Claim/encounter is adjudicated, audited and priced appropriately
- Processing results are recorded and ready for distribution as necessary

Shared Data/Interfaces:

- MMIS
- DSS
- COFRS
- CBMS
- DORA
- PDCS
- COLD
- Web Portal
- Department LAN (flat file)

To Be:

- Unique identification field for Managed Care Org
- Ability to assign as many provider types to a claim as necessary; flexibility to add at will
- Flexibility for users to define fields (for reporting, payment adjudication, etc.) with minimal cost and time
- Ability to implement user-defined adjudication rules (e.g., to specific populations groups)
- Electronic attachments
- Ability to feed information into new DSS that has same type of flexibility as the new MMIS
- Cooperative relationship between Fiscal Agent and State to implement changes to the system

and/or business rules
- Ability to implement changes quickly
- Reduce need for operational manual work-around
- Track specific pricing mechanism applied (e.g. fee schedule, procedure modifier, etc.) and the original rate applied *before* other modifications (e.g. lower-of-pricing, copays, TPL payments, etc.)
- Capture client eligibility information applicable at adjudication
- Ability to quickly and easily track the 'life' of a claim/service from original submission through all adjustments; simply identify most recent claim (final claim) in the chain

Failures:

- Flat files are required for BHO/Mental health encounters
- MMIS does not allow encounter data to be handled differently than claims data
- MMIS does not allow different users to assign different benefits
- MMIS does not allow MCO as a type of provider
- Inflexibility of hard-coded claims adjudication rules creates issues
- Cost and time of changing anything (in either of the systems) adjudication rules; CSR back-log
- Lack of FTEs to make adjudication rules changes
- Manual work-around required due to system inflexibility and CSR back-log
- Limited ability to determine pricing mechanism and/or original rate applied to claim
- Limited ability to assign claims to specific populations (e.g. Tobacco Tax, 1293) when incorporating eligibility span data due to retroactive eligibility changes (many of these issues have been resolved via CSRs over the past few years)

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Apply Claim Attachment
Author(s): Joan Welch, Nellie Pon, Sandy Salus, John Aldag, Vernae Roquemore, Sarah Campbell, Sharon Liu, Nathan Culkin, René Horton, Jon Meredith, Carol Reinboldt	
Facilitator: Kassie Gram	
***Actors*:** Reviewing agencies (Fiscal Agent, Contractors), Department staff, County staff, Providers, Clients	
Description: The ***Apply Claim Attachment*** business process begins with receiving an attachment that has either been requested by the payer (solicited) or has been sent by the provider (unsolicited). The solicited attachment(s) can be in response to requests for more information from the following claim auditing, authorization of services and benefit and estate recovery. • Claims attachment, which must be submitted with the claim • Prior Authorization attachment, submitted with the PAR or pended if attachment is not provided • Treatment Plan attachment, submitted with the PAR if needed	
Precondition: Services requiring attachments are needed.	
***Trigger(s)*:** • Authorization is submitted to reviewing agency • Claim/Authorization is submitted to Fiscal Agent/MMIS	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M**	***Steps*:** 1. **Start**: Reviewing Agency or Department staff **receives** claim/authorization 2. Reviewing Agency or Department staff **reviews** Claim/authorization attachment for completion 3. Reviewing Agency or Department staff v**erify** attachment is appropriate for claim/authorization a. PAR is approved, pended or denied b. Claim is paid or denied (including reconsiderations) 4. End: Attachment is **archived** after the decision is made

***Outcome*:**

- Claim/authorization is finalized
- Services are either approved or not approved

Shared Data/Interfaces:

- Docfinity (scanning database)
- BUS
- CCMS
- Web Portal (does not hold the attachment)
- MMIS (does not hold the attachment)
- DSS (does not hold the attachment)

To Be:

- Attachments are stored in the DSS
- Attachments are stored in the MMIS
- Attachments are linked to the claims/authorizations
- Electronic Health Record interface
- More accessible attachment data to monitor appropriateness of services provided
- Attachments are searchable via current mechanisms (e.g. character recognition software)

Failures:

- No electronic attachments to the claim/authorization
- Attachments are not centralized
- Difficulty finding attachments for claims/authorizations
- Attachments are separate from claims/authorization

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Apply Mass Adjustment
Author(s): Joan Welch, Nellie Pon, Sandy Salus, John Aldag, Vernae Roquemore, Sarah Campbell, Sharon Liu, Nathan Culkin, René Horton, Jon Meredith, Carol Reinboldt	
Facilitator: Kassie Gram	
***Actor(s)*:** Department staff, Fiscal Agent, MMIS, DSS	
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 payment transactions such as claims or capitation payment records by identifiers including, but not limited to, claim/bill type, 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 may reverse or amend the paid transaction and repay correctly.	
Precondition: Claims have been adjudicated	
***Trigger(s)*:** • Rate adjustments • Legislation • Policy changes • Transmittals • Identification of payment errors and accounting errors • Identification of payment recovery from Program Integrity review	
Manual (M) or Automated (A) **1. M** **2. M** **3. A** **4. M/A** **5. A** **6. M/A**	***Steps*:** 1. Start: Department staff **identifies** claims/criteria for adjustment 2. Department staff **submits** a request for adjustment 3. Fiscal Agent **performs** MMIS mass adjustment 4. Fiscal Agent/Department staff **notify** Providers of mass adjustment as appropriate a. If adjustment is “pay to provider”, the provider is notified b. If “history only”, a provider is not notified 5. **Process** claims according to transmittal instructions or standard

	processing rules 6. End: **Finalize** claims
***Outcome*:** Claims have been mass adjusted	
Shared Data/Interfaces: • MMIS • TrackWise • DSS • COLD • Web Portal • COFRS	
To Be: • Allow more complex, pre-defined and unlimited match criteria • Ability to mass adjust encounters and capitations • Ability to apply partial recoveries to claims • Flexible notification of history-only processing • Automated process to take most recent chain • Ability to determine the claims / ranges / situations to which the mass adjustment applies (e.g. CPT Code ##### for claims paid 7/1/2012-8/15/2012)	
Failures: • If mass adjustments have not been applied timely, edits application becomes more and more manual • Lack of timeliness of notification of rate/code changes • Provider education • Not able to mass adjust Managed Care capitation payments • Inflexibility of system and defining criteria for finding mass adjusted claims • Inability to apply mass adjustments to original/applicable claims when reporting • Limitations in the number of data elements that you can specify for mass adjustments • History-only mass adjustments are not communicated to providers; communication to providers is causing provider confusion • No chain of partial recovery in MMIS (HMS)	
Notes: *No notes captured.*	

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare Remittance Advice Report
Author(s): René Horton, Greg Tanner, Bret Pittenger, Juanita Pacheco, Cindi Mason, Shane Mofford, Sandy Salus, Jay Puhler, Joanne Svenningsen, Carol Reinboldt, Jon Meredith	
Facilitator: Jennifer Kraft	
***Actor(s)*:** Fiscal Agent, MMIS, CS&O, Controllers Division, Program staff, Providers	
Description: The **Prepare Remittance Advice Report** business process describes the process of preparing remittance advice EDI transactions that will be used by providers to reconcile their accounts receivable. **NOTE 1:** Encounter data does not go through financial processing in the MMIS. There is no remittence report generated for encounter data. **NOTE 2:** This process does not include sending the remittance advice EDI Transaction.	
Precondition: Submitted claims, transmittals (i.e. financial, suspension of service, mass adjustments)	
***Trigger(s)*:** • Provider submits claims • Financial cycle process (occurs weekly on Friday night)	
Manual (M) or Automated (A) **1. A** **2. A** **3. A** **4. A** **5. A** **6. A**	***Steps*:** 1. Start: **Run** claim validation preprocess for syntax errors a. Accept b. Reject 2. **Load** accepted claim into MMIS 3. MMIS **reviews** and **sets** edits claim 4. MMIS **adjudicates** claim 5. Claims **roll** into financial cycle 6. End: RA Reports are **created** and **available** for providers to access on the Web Portal (or mailed with State Warrants if elected by Provider)

***Outcome*:** RA Reports are prepared.
Shared Data/Interfaces: • MMIS • File Report Service (FRS) (Web Portal) • COLD (Computer Output Laser Disk) • DSS
To Be: • No Paper • Be NPI based rather than State Provider ID (pay and report) • Expand DSS to include suspended claims • All reporting is done in the DSS (not from production environment) • New DSS to include all information in MMIS • New DSS to be updated more frequently to allow more frequent reporting
Failures: • Inflexible report (proprietary report does not contain enough detail and cannot be updated without a CSR) • All information necessary to generate report not included in DSS
Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare COB
Author:	
***Actor*:**	
Description: The ***Prepare COB*** business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. Claims are flagged and moved to a COB file for coordination of benefit related activities based on predefined criteria 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***.	
Notes*: **SMEs indicated that this does not apply to the Colorado Medicaid program*	

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare Home and Community-Based Services Payment
Author(s): René Horton, Greg Tanner, Bret Pittenger, Juanita Pacheco, Cindi Mason, Shane Mofford, Sandy Salus, Jay Puhler, Joanne Svenningsen, Carol Reinboldt, Jon Meredith	
Facilitator: Jennifer Kraft	
***Actor(s)*:** Fiscal Agent, MMIS, CS&O, Controllers Division, Program staff, Providers	
Description: The **Prepare Home and Community-Based Services Payment** business process describes the preparation of the payment report. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. For Colorado, there is not a different process for Prepare HCBS payment report vs. RA Report. **NOTE:** This process does not include sending the home & community based provider payment data.	
Precondition: Submitted claims, transmittals (i.e., financial, suspension of service, mass adjustments)	
***Trigger(s)*:** • Provider submits claims • Financial cycle process (occurs weekly on Friday night)	
Manual (M) or Automated (A) **1. A** **2. A** **3. A** **4. A** **5. A** **6. A**	***Steps*:** 1. Start: **Run** claim validation preprocess for syntax errors a. Accept b. Reject 2. **Load** accepted claim into MMIS 3. MMIS **reviews** and **sets** edits claim 4. MMIS **adjudicates** claim 5. Claims **roll** into financial cycle 6. End: RA Reports are **created** and available for providers to access on the Web Portal (or mailed with State Warrants if elected by Provider)

***Outcome*:** RA Reports are prepared. (For Colorado, there is not a different process for Prepare HCBS payment report vs. RA Report.)
Shared Data/Interfaces: • BUS • CCMS (Community Contract and Management System) • MMIS • File Report Service (FRS) (Web Portal) • COLD (Computer Output Laser Disk) • DSS
To Be: • Integrate BUS (LTC Case Management System) with MMIS • Consolidate Case management function (CCMS - PARs in one place) • Expand DSS to include suspended claims • All reporting is done in the DSS (not from production environment) • New DSS to include all information in MMIS • New DSS to be updated more frequently to allow more frequent reporting
Failures: • Inflexible report (proprietary report cannot be updated without a CSR) • All information necessary to generate report not included in DSS
Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare EOB
Author(s): Jay Puhler, Nellie Pon, Joan Welch, Tanya Chaffee, Nancy Downes	
Facilitator: Kassie Gram	
***Actor(s)*:** Fiscal Agent, MMIS, Providers, Program Integrity, Benefit Management Staff, Clients	
Description: The ***Prepare EOB*** business process includes producing explanation of benefits (EOBs), distributing the EOBs, and processing returned EOBs to determine if the services claimed by a provider were received by the client. This process also includes any standardized schedules related to EOBs and letters. EOB, PCR = Provider Claim Report, RA = Remittance advice	
Precondition: • Provider provides service • Transmittals (financials, suspension of service, mass adjustments) • Confidential Services are excluded from EOMBs	
***Trigger*:** • Adjudication process • Provider submits claim (manual or auto, 99% auto) • Financial cycle	
Manual (M) or Automated (A) **1. A** **2. A** **3. A** **4. A**	***Steps*:** 1. Start: Claim has been **accepted** in MMIS 2. MMIS **Adjudicates** claim 3. Financial cycle **runs** 4. End: EOB is **created**
***Outcome*:** EOB is prepared and quality checked to ensure NO confidential services are on any of the EOMBs being sent to clients	

Shared Data/Interfaces:

- Web Portal
- MMIS
- COLD
- DSS
- EDI

To Be:

- All electronic
- Be NPI based rather than state provider ID (Pay & Report)
- Expand DSS to include as many reports as possible from COLD (all reporting in DSS)
- New DSS to include all information in MMIS
- Quality Assurance process to ensure Confidential Services are NOT included on any EOMB
- Eligibility subsystem/system of record includes interface to update client address and telephone numbers and/or clients have ability to update contact information online so EOBs can reach the client

Failures:

- Paper
- Inflexible reporting (MMIS production)
- Difficulty in extracting data for HIPAA reporting purposes
- Confidential services have been sent on EOBs
- Client contact information is frequently incorrect

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare Provider EFT/Check
Author(s): Rene Horton, Greg Tanner, Bret Pittenger, Juanita Pacheco, Cindi Mason, Shane Mofford, Sandy Salus, Jay Puhler, Joanne Svenningsen, Carol Reinboldt, Jon Meredith	
Facilitator: Jennifer Kraft	
***Actor(s)*:** COFRS, Accounting staff, MMIS, Fiscal Agent, Providers	
Description: The **Prepare Provider EFT/Check** business process is responsible for managing the generation of electronic and paper based reimbursement instruments for providers, including but not limited to: • Calculation of payment amounts for a wide variety of claims. • Dispersement of payment from appropriate funding sources per State and Agency Accounting and Budget Area rules.	
Precondition: • Process claims • Transmittals (i.e., financial, suspension of service, mass adjustments)	
***Trigger*:** • Financial cycle • File transfer from MMIS to COFRS	
Manual (M) or Automated (A) **1. A** **2. A** **3. A** **4. A** **5. M/A** **6. A**	***Steps*:** 1. Start: MMIS data is **received** by COFRS. 2. **Goes** through COFRS NPC (Nightly Process Cycle) edits. 3. Accept/Reject process **occurs.** 4. Accepted payments **go** through the Warrants/EFT cycles. 5. Warrants are **printed** and **delivered** to OSC, **picked up** and **mailed** by Fiscal Agent. 6. End: EFTs are **sent** to the Automated Clearing House (ACH) and deposited into Provider accounts.
***Outcome*:** Providers are paid	

Shared Data/Interfaces:

- MMIS to COFRS
- COFRS to MMIS
- DSS
- COFRS to ACH
- COFRS to IDS (State Agency for Warrant Printing)

To Be:

- Payments made outside of MMIS adjudication – consolidate all payments currently not started from the MMIS, but associated with Medicaid and/or CHP+, in the MMIS
- In MMIS, associate claims with COFRS warrant numbers after warrants are generated
- In MMIS, receive feed from COFRS / Accounting tracking pended or rejected payment information (e.g. p.v.'s and j.v.'s) and associate the identified payments with their source claims
- Flexibility in the MMIS to quickly, easily, and inexpensively develop and/or update accounting and budget codes to enable accurate fiscal analysis and reporting

Failures:

- 25% of payments are not made from MMIS (Administrative Payments: Nursing Homes, Hospital Supplemental Payments, Medicare Buy-in, Transportation, etc.)
- Interfacing with COFRS creates a delay in Provider's reconciliation process
- Interface with COFRS must be manually recreated by State staff for audit and reconciliation process
- Due to the way the data comes in, there is no ability to reconcile RA statements with claims data
- Expensive and time-consuming processes required to update accounting and budget codes result in funds being inaccurately categorized in the MMIS and DSS; results in manual workarounds by accounting and budget staff outside of the MMIS
- Payee name and/or address in COFRS may be different from MMIS, resulting in the RA going to one place and the warrant to another.

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare Premium EFT/Check
Author(s): René Horton, Greg Tanner, Bret Pittenger, Juanita Pacheco, Cindi Mason, Shane Mofford, Sandy Salus, Jay Puhler, Joanne Svenningsen, Carol Reinboldt, Jon Meredith	
Facilitator: Jennifer Kraft	
***Actor(s)*:** Program staff/Contract Manager, Contracts & Purchasing, Accounting staff, Budget staff, Safety Net staff, Contractor, COFRS	
Description: The **Prepare Premium EFT/Check** business process is responsible for managing the generation of electronic and paper based reimbursement instruments. Payments for services not associated with a claim.	
Precondition: Services must be rendered by Vendor/Contractor.	
***Trigger(s)*:** • Receipt of Invoice and receiving report • Payment cycle • Supporting document provided to Accounting • Settlement Agreement is received • Audit	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. A** **5. A** **6. A** **7. M/A** **8. A**	***Steps*:** 1. Start: **Receive** appropriate documents. 2. Payment manually **entered** into COFRS. 3. **Approved** by Accounting Staff. 4. **Goes** through COFRS NPC (Nightly Process Cycle) edits. 5. Accept/Reject process **occurs**. 6. Accepted payments **go** through the Warrants/EFT cycles. 7. Warrants are **printed** and **delivered** to and **mailed** by OSC. 8. End: EFTs are **sent** to the Automated Clearing House (ACH) and deposited into Vendor/Provider accounts.

	Note: If not approved – errors are addressed by Accounting.

***Outcome*:** Vendor/Provider is paid

Shared Data/Interfaces:

- COFRS to IDS (State Agency for Warrant Printing)
- ACH

To Be:

- Payments made outside of MMIS adjudication – consolidate all payments currently not started from the MMIS, but associated with Medicaid
- No Paper
- Be NPI based rather than State Provider ID (pay and report)
- All reporting in the DSS (not from production environment)
- New DSS to include all information in MMIS

Failures:

- Time consuming
- Manual – Human Error
- Doesn't reconcile to MMIS
- Untimely payments
- Antiquated legacy system has a limited lifespan
- Lack of institutional knowledge to maintain/update existing Accounting system

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare Health Insurance Premium Payment
Author(s): Jay Puhler, Sharon Brydon, Greg Tanner, Vicki Foreman, Paula Ring, Juanita Pacheco, Jon Meredith, Steve Hunter, Shane Mofford	
Facilitator: Kassie Gram	
***Actor(s)*:** Health Insurance Buy-in officer (HIBI), MMIS, Fiscal Agent, COFRS, Client or advocate, County Department of Human Services, third party insurers	
Description: The ***Prepare Health Insurance Premium Payment*** business process covers payment of private health insurance premiums for any clients who have private health insurance benefits because it is determined to be cost effective to the Medicaid program.	
Precondition(s): • Client has to be eligible for Medicaid • Health insurance shows active in system • HIBI tab in MMIS has to be set up for payment (as apposed to suspended) • HIBI payee needs to be active in MMIS and COFRS	
***Trigger*:** HIBI cycle is run (monthly)	
Manual (M) or Automated (A) ***Initial*** **1. M** **2. M** **3. M** **4. M** ***Ongoing*** **1. M** **2. M** **3. M** **4. M** **5. M/A** **6. M**	***Steps*:** **Initial Sequence:** 1. Start: **Verify** that regular HIBI amount is correct 2. **Calculate** HIBI amount for that month (if different than auto payment) 3. HIBI officer **sets up** initial payment 4. End: **Capture** screen shot of payment and backup documentation and put into HIBI tab updates folder **Ongoing Sequence:** 1. Start: **Capture** and **analyze** plan and/or rate changes 2. **Update** TPL file with new information in MMIS and CBMS and Access database 3. **Calculate** HIBI amount for that month (if different than auto payment) 4. HIBI officer **sets up** underpayment/overpayment 5. **Reset** HIBI tabs to regular monthly amount (automated after reset to

7. M **8. M** **9. M** **10. M** **11. A** **12. M** **13. M**	regular monthly amount) 6. **Capture** screen shot of payment and backup documentation and put into HIBI tab updates folder 7. **Run** report out of access 8. **Compare** Access check off list to HIBI prelim COLD report generated out of MMIS 9. **Record** any oddball/discrepancy payments on prelim 10. **Make** adjustments for error messages on the prelim 11. **Run** final report 12. **Compare** prelim to final and note an changes/discrepancies 13. End: **Generate** an attachment transmittal to fiscal agent
***Outcome*:** A HIBI payment is prepared	
Shared Data/Interfaces: • Access database • MMIS • CBMS • COFRS • DSS • COLD	
To Be: • Automate process • Carve out CBMS from process for TPL resource file • More flexibility for payments • Enhanced reporting	
Failures: • Eligibility ends and will not allow payment • Health insurance policy is showing an end date and will not allow payment • HIBI payee/provider is inactive or does not exist • Data entry errors on HIBI tab • Time and resources • Manual processing and workarounds	
Notes: *CHIP+ payment pilot process does not follow these steps; however, it looks as though it will stay a pilot and go away with health care reform*	

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare Medicare Premium Payment
Author(s): Jay Puhler, Sharon Brydon, Greg Tanner, Vicki Foreman, Paula Ring, Juanita Pacheco, Jon Meredith, Steve Hunter, Shane Mofford	
Facilitator: Kassie Gram	
***Actor(s)*:** Medicare Buy-in Officer, Accounting, CMS, SSA, DHHS, County Dept of Human Services, COFRS, MMIS (eligibility data), Railroad Retirement Board (RRB), Civil service, CMS	
Description: State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost sharing, defined as premiums. Under the buy-in process, State Medicaid agencies, CMS, the Social Security Administration (SSA) and DHHS enter into a contract where states pay the Medicare beneficiary share of premium costs. Note: This will include actual payment. The ***Prepare Medicare Premium Payments*** business process is the reciprocal exchange of eligibility information between Medicare and Medicaid agencies, reviewing any matches between MMIS and Medicare, generating buy-in files for CMS for verification, and providing the premium payment within the required output (reports/data set). **NOTE:** This process does not include sending the Medicare premium payments EDI transaction.	
Precondition(s): • Client eligibility, demographic, and Medicare data must be entered into MMIS and match CMS data • Client is enrolled in Medicaid or Medicare Savings Program (MSP)	
***Trigger(s)*:** • Receive electronic billing file from CMS • Receive paper summary account statements (invoice) from CMS	
Manual (M) or Automated (A) **1. A**	***Steps*:** 1. Start: MMIS **receives** data in client eligibility file from CBMS indicating client accretion (add), deletion or change transactions

2. A **3. A** **4. A** **5. A** **6. A** **7. A/M** **8. M** **9. M** **10. M** **11. M** **12. M**	2. **Create** weekly buy-in file, according to schedule 3. **Submit** buy-in file to CMS, according to schedule 4. CMS **processes** and **responds** to State requests and includes CMS identified client record updates 5. State **receives** CMS responses 6. State **receives** monthly billing file from CMS, which includes the premium amounts to be paid 7. State **validates** data and **posts** transactions to MMIS a. County Workers are **notified** of rejects and take appropriate action 8. Medicare Buy-in Officer **generates** COLD report based on MMIS data to prepare Medicare premium payment 9. Medicare Buy-in Officer **verifies** amounts in COLD reports are balanced to invoice 10. Medicare Buy-in Officer **sends** supporting documentation to accounting 11. Accounting **verifies** supporting documentation 12. End: Accounting **creates** payment in COFRS

***Outcome*:** CMS is paid for the Medicare beneficiary share of premium costs.

Shared Data/Interfaces:

- COFRS
- MMIS
- CMS
- COLD
- OIT (state mainframe)
- CMS
- Fiscal Agent
- CBMS

To Be:

- Buy-in information is held in DSS
- Automate verification process
- Automate payment through MMIS
- Create a direct interface from MMIS to CMS (bi-directional)
- Ability to generate a RIC S out of the reconciliation table (recon table – clients that could not be loaded into the MMIS)
- Increased flexibility to audit and manage logic
- Receive most recent application date from CBMS on an interface directly with MMIS
- Enhanced ability to track clients that move in and out of the state (and its impact on Medicare

buy-in eligibility)
- Ability for MMIS to receive BENDEX file; or receive Medicare information
- Improved reporting (e.g., ability to run out of state data using a configurable older than date)
- Provide electronic report access to counties
- Ability to create ad hoc reports
- New DSS that includes buy-in information
- Ability to perform mass mailing or correspondence function
- Ability to archive historical billing file
- Ability to archive buy-in records over two years
- Ability to easily configure processing and reporting frequency
- Configurable values

Failures:

- Human error
- Inaccurate data from CMS or CBMS
- FFP issues related to payment
- Eligibility span issues
- Time and resource intensive
- CMS summary statement not received
- Failures that result in monetary losses to State (late payment issues cost the State interest money)
- When CMS initiates buy-in, unable to terminate buy-in for clients that State is being incorrectly billed for, because they are not in the MMIS
- Financial impact of buy-in termination logic; current logic misses people (and they continue to collect benefits when they should not)
- Inconsistency of logic
- MMIS does not receive data indicating when a person moves out of the state and back, there is no way to identify the most recent application date is missing
- Billing file is overwritten with each cycle; losing audit history
- CBMS data entry errors or inconsistencies resulting in MMIS / CMS mismatches (e.g. entering 'Sally' rather than 'Sarah')

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process***: Prepare Capitation Premium Payment
Author(s): Jay Puhler, Parrish Steinbrecher, Sharon Brydon, Greg Tanner, Sarah Campbell, Sharon Liu, Vicki Foreman, Joel Dalzell	
Facilitator: Kassie Gram	
***Actor*(s):** Rates staff, Managed Care providers and staff, Medicaid Reform Unit, CBMS, TRAILS, CMS, Fiscal Agent	
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 may include: • A correspondence schedule stipulated by Trading Partner Agreement • Includes retrieving enrollment and benefit transaction data from MMIS • Retrieving the rate data associated with the plan from the MMIS Provider or Contractor information • Formatting the payment data into the required data set or report **NOTE:** This process does not include sending the capitation payment data.	
Precondition(s): • Contract is in place • Rates are set and approved • Clients are enrolled into organizations • Enrollment information is available • Population is defined • Provider information is available • Benefit is defined	
***Trigger(s)*:** • Regulations • Calendar • Benefit change • Set schedules in MMIS	

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- Eligibility report is generated and triggers the financial cycle

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Manual (M) or Automated (A)

1. **M (initially)/A (ongoing)**
2. **A**
3. **A**
4. **A**
5. **A**
6. **A**

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***Steps*:**

1. Start: **Identify** effective date
2. **Run** eligibility and demographic data
3. **Determine** client enrollment status by provider
4. **Run** Financial cycle
5. Managed care reports **created**
6. End: **Send** payment information to COFRS

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***Outcome*:** Capitation payment is prepared and ready for payment

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Shared Data/Interfaces:

- COFRS
- CBMS
- MMIS (stores cap payments)
- DSS
- COLD
- Recovery vendor (share cap data)

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To Be:

- Pay rates not just based on demographic and eligibility
- More flexibility (ability to change rates on the fly)
- Enhanced and more static reporting
- Data automatically feeds into payment of rate
- Risk adjusted payments based on current, live data
- Set client-specific rates
- Better synchronized enrollment and financial cap reporting
- Automated reconciliation of retroactively disenrolled clients

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Failures:

- Replicating data out of MMIS for cap reporting vs. DSS (they are not in sync)
- Difference between dynamic and static data (e.g. retroactive eligibility changes)
- Manual reconciliation occurs for retro disenrolled clients
- Inaccurate TPL information; causes cap rate to change
- Source data integrity

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Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Manage Payment Information
Author(s): Jay Puhler, Nellie Pon, Joan Welch, Tanya Chaffee	
Facilitator: Kassie Gram	
***Actor(s)*:** MMIS, Program/Policy Staff, Fiscal Agent Operations, Accounting Staff, Rate Staff, Program Integrity Staff	
Description: The ***Manage Payment Information*** business process is responsible for managing all the operational aspects of the MMIS, which is the source of comprehensive information about payments made to and by the state Medicaid enterprise for healthcare services. Included in this business process are activities related to requests to MMIS to add or append data in payment records. MMIS validates data upload requests, applies instructions, and tracks activity.	
Precondition: • Paid claim • Claim submitted	
***Trigger*:** • A need to change a payment • Rate adjustment • Legislation • Policy change • Audit/Legal	
Manual (M) or Automated (A) **1. A** **2. M** **3. M** **4. M** **5. A**	***Steps*:** 1. Start: Claim is **paid** 2. **Adjustment** is required (e.g., rate adjustment, legislation, policy change, audit, legal) 3. State staff **submits** a Transmittal (via TrackWise) 4. Fiscal agent **processes** transmittal 5. End: MMIS **processes** request according to financial cycle

***Outcome*:** Adjustment is made
Shared Data/Interfaces: • MMIS • COLD • DSS • COFRS for payment • TrackWise • Web Portal
To Be: • Ability for State Staff to remove steps in transmittal process and perform updates directly to MMIS • Ability to track the algorithm used to determine which payment process would be applied (e.g. fee schedule, order of precedence when using the procedure modifier rate table, etc.) • Complete rate and payment data available in DSS
Failures: • Processing of requests (human error) • Paper • Time and resource constraints • Difficult to impossible to determine order of precedence for procedure modifier rates
Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Inquire Payment Status
Author(s): Jay Puhler, Nellie Pon, Joan Welch, Tanya Chaffee	
Facilitator: Kassie Gram	
***Actor(s)*:** Providers, MMIS, DSS, Data Staff, CS&O Staff, Web portal, Accounting, AVR (Automated Voice Response), Fiscal Agent, External Data Request Board, Auditors, Contract Managers, Client, SDAC	
Description: The ***Inquire Payment Status*** business process is how the Department processes and responds to a request for information regarding the current status of a specified claim, payment history data, recording claim status response and pulling the information into the right format for response (i.e., 277 Claim Status Response, or other paper/phone/fax format). This can be triggered by receipt of either a 276 Claim Status Inquiry transaction or a request for information (via paper, phone, fax or AVR request).	
Precondition: • Requirement for Claim Information: o Services Provided o Claim Submitted	
***Trigger*:** Request for information	
Manual (M) or Automated (A) **1. M** **2. M** **3. M, A (web/AVR)** **4. M, A (web/AVR)** **5. M, A (web/AVR)**	***Steps*:** 1. Start: Inquiry **received** 2. Inquiry is **authenticated** and **approved** (as appropriate) 3. Inquiry is **routed** 4. Inquiry is **investigated** (as appropriate) 5. End: Response is c**ommunicated**
***Outcome*:** Response to inquiry provided	

Shared Data/Interfaces:

- MMIS
- DSS
- Web Portal
- AVR
- COLD
- COFRS
- SDAC

To Be:

- New DSS
- Improved reporting
- Improved information sharing between MMIS and COFRS
    a. Indicate offsets via notifications between systems
    b. Associate EFT/warrant numbers with specific claims in MMIS
- Contractor-specific data access (controllable by roles/permissions)

Failures:

- Contractor requires State staff to process data access / reporting needs
- Transactional failures between MMIS and Web Portal (X12 interface / service processing)
- Reconciliation between MMIS and COFRS

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Prepare Member Premium Invoice
Author(s): Christine Martinez, Linda Smidt	
Facilitator: Kassie Gram	
***Actor(s)*:** Clients (Denver Health employees), CHP+ staff, Accounting staff, Access database, CBMS	
Description: The ***Prepare Member Premium Invoice*** business process includes retrieving client premium information, performing required data manipulation according to business rules, formatting the results into required output format, and producing client premium invoices. This process includes the standard timetable for scheduled invoicing. States may implement client/member cost sharing through the collection of premiums for medical coverage provided under the Medicaid/SCHIP umbrella. In the State of Colorado, this program is called CHP+ at Work. **NOTE:** This process does not include sending the client premium invoice EDI transaction.	
Precondition: Denver Health employee and one child on Denver Health insurance	
***Trigger*:** Client completes Medicaid/CHP+ application and submits to the Department	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M**	***Steps*:** 1. Start: **Receive** application 2. CHP+ staff **review** application for completeness and required documentation 3. **Contact** applicant if additional documentation is needed 4. **Enter** application information in Access database 5. **Determine** eligibility using Access database 6. **Send** letter of approval/denial 7. **Monitor** payment processing on a monthly basis 8. **Forward** payment processing reports to Accounting 9. Accounting **processes** client premium payment
***Outcome*:** Member premiums are reimbursed	

Shared Data/Interfaces:

- CBMS
- COFRS
- Access database
- Reports for Accounting
- Reports for client employer

To Be:

- Integrate the program with existing systems (CBMS or MMIS)
- Flexible MMIS, with ability to add new programs as needed
- Automate – reduce paper
- Online submission of applications

Failures:

- Process is all manual
- Program processing can't be added into CBMS
- Clients don't always display on report and checks don't get issued
- Insufficient database (Access)
- Only a couple of established reports built into the Access database; other data requests must be made through Claims System Support (CSS)

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process***: Calculate Spend-Down Amount
Author(s):	
Facilitator:	
***Actor*:**	
Description: A person that is not eligible for medical coverage when they have income above the benefit package or program standards may become eligible for coverage if they have medical bills that equal or are greater than their "excess" income. The process of subtracting those medical bills from the individual's income over a six-month period is called a Medicaid "spend-down." The ***Calculate Spend-Down Amount*** business process describes the process by which spend-down amounts are tracked and a client's responsibility is met through the submission of medical claims. The spend down amount is tracked by claims processing and results in a change of eligibility status once spend-down has been met which allows for Medicaid payments to begin and/or resume. For example, this occurs in situations where a client has a chronic condition and is consistently above the resource levels, but may also occur in other situations.	
Notes: ****SMEs indicated that this does not apply to the Colorado Medicaid program****	

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Manage Recoupment
Authors: Jay Puhler, Sharon Brydon, Eujenia Renfro, David Smith, Shirley Jones, Greg Donlin, Shane Mofford, Nancy Downes	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** HMS, Program Integrity, Accounting, Benefits Coordination, Fiscal Agent Operations, Fiscal Agent, Audits, MFCU (Medicaid Fraud Control Unit), MMIS, CBMS, Provider	
Description: The ***Manage Recoupment*** business process describes the process of managing provider recoupment. Provider recoupment is initiated by the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where monies are owed to the agency due to fraud/abuse. Recoupments can be collected via check sent by the provider or credited against future payments for services.	
Precondition: Overpaid claim	
***Trigger*:** Identification of overpayment	
Manual (M) or Automated (A) **1. M/A** **2. M** **3. M** **4. M** **5. A** **6. A** **7. M**	***Steps*:** 1. Department identifies or **receives** overpayment notification 2. **Validation** of overpayment 3. **Initiate** recovery process with provider, OR 4. **Transmittal** to fiscal agent 5. MMIS **performs** adjudication 6. **Recovery** through financial cycle or direct provider payment via check 7. Manual **reclassification** of revenue
***Outcome*:** Overpayment is recovered	

Shared Data/Interfaces:

- DSS
- MMIS
- COFRS
- CBMS
- Web Portal
- COAD (Colorado Authoritative Document)
- Trackwise

To Be:

- Automate revenue reclassification process
- Additional automation, minimize paper transactions (currently fiscal agent hand-keys data)
- Claims need to be "marked" or "coded" so subsequent audits can see previously recovered claims.

Failures:

- Human error
- Data from eligibility system overwrites historical MMIS data
- Additional steps are required to submit "ghost" claims, which can be misleading to external auditors using MMIS data. These are history only claims to mark recoveries.

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Manage Estate Recovery
Authors: Jay Puhler, Sharon Brydon, Eujenia Renfro, David Smith, Shirley Jones, Greg Donlin, Shane Mofford, Nancy Downes	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Estate Recovery contractor, Benefits Coordination, Attorneys, Probate Court, AG Office, CDPHE, Peer Review Organization, Provider, CBMS, MMIS, and DSS	

Description:

Estate recovery is a process whereby States are required to recover certain Medicaid benefits paid on behalf of an individual. This is done by the filing of liens against a deceased member's estate to recover the costs of Medicaid benefits paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, ICF/MR, or other medical institution.

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 (e.g., demand of notice to probate court, generating notice of intent to file claim and exemption questionnaire) opening a formal estate recovery case based on estate ownership and value of property, determining value of estate lien, files petition for lien, files estate claim of lien, conducts case follow-up, sending information to accounting, releasing the estate lien when recovery is completed, and updating MMIS.

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.

In Colorado, parts of this process are outsourced to an estate recovery contractor.

Precondition(s):

- Age
- Receipt of Claim
- Estate

***Trigger(s)*:**

- Death
- PRO Determination

Manual (M) or Automated (A)	***Steps*:**
1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M**	1. **Receive** PRO Determination – not likely to return to home 2. **File** lien 3. **Receive** notification of death 4. **Record** date of death in CBMS 5. **Pass** date of death to MMIS through interface 6. **Assert** lien 7. **Petition** court, if estate unopened within 1 year 8. **Conduct** probate process 9. **Recover** funds 10. **Record** as a reduction in prior year expenditures 11. Manual **reclassification** of revenue

***Outcome*:** Recover funds

Shared Data/Interfaces:

- CBMS
- MMIS
- Social Security
- CDPHE
- COFRS
- DSS
- Vendor System

To Be:

- Improved link with national records
- Link with Colorado Vital Statistics
- Asset reconciliation with Accurant (LexisNexus)
- Improved Automation (Date of Death notification) and Tracking (where applicable)

Failures:

- Inaccurate or incomplete information
- Human error
- No access to Vital Statistics data

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Manage TPL Recovery
Authors: Jay Puhler, Sharon Brydon, Eujenia Renfro, David Smith, Shirley Jones, Greg Donlin, Shane Mofford, Nancy Downes	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Clients, providers, counties, HMS, insurance carriers, Program Integrity, Fiscal Agent, personal injury attorneys, Benefits Coordination, CBMS, and MMIS	
Description: The ***Manage TPL Recovery*** business process begins by receiving third party liability data from various sources - such as external and internal data matches, clients, tips, referrals, attorneys, Program Integrity/Fraud & Abuse, Medicaid Fraud Control Unit, providers and insurance companies - identifying the provider or TPL carrier, locating recoverable claims, creating post-payment recovery files, sending notification data to other payer or provider, receiving payment from provider or third party payer, sending receivable data, and updating 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. Colorado State Plan provides that the Department will both cost avoid and pay/chase.	
Precondition(s): • Enrolled client • Paid claim	
***Trigger*:** Identification of any actor or entity who is legally responsible to pay for claim, including cost avoidance.	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M/A** **5. A**	***Steps*:** -Commercial Health Cost Avoidance 1. **Receive** Notification (MS10, CBMS, etc.) 2. **Verify** TPL coverage 3. **Enter** TPL information in CBMS 4. **Transfer** TPL information to MMIS through interface 5. MMIS **cost avoids** claim

1. **A** 2. **A** 3. **A** 4. **M/A** 5. **A** 6. **M/A** 7. **M** 8. **A**	-Commercial Health Coverage (Pay / Chase) 1. **Transfer** MMIS eligibility and claim files to HMS (TPL contractor) 2. HMS **performs** data matching of Medicaid eligibility data against commercial health plan eligibility data to determine whether a Medicaid recipient has other coverage 3. If Yes: **Match** claims data with commercial health plan eligibility span 4. **Initiate** retraction process with provider (institutional - manual), or **submit** claim to entity for payment (professional – can be EDI or paper) 5. If HMS receives payment, **route** claims adjustment file to MMIS 6. For institutional: **send** letter notifying provider of pending retraction with facility 7. **Receive** response from institution 8. HMS **adjusts** claims in MMIS
1. **M** 2. **M** 3. **M** 4. **M** 5. **M**	-Tort & Casualty 1. **Identification** via potential litigation or claims process 2. **Calculate** amount of medical claims paid by Medicaid related to tort 3. **Assert** Medicaid lien 4. **Ascertain** parties rights 5. **Recover** lien
1. **M/A** 2. **A**	-Medicare Cost Avoidance 1. CBMS **receives** notification of Medicare eligibility 2. If TPL code indicates Medicare, a. **Transfer** to MMIS through interface b. MMIS **cost avoids** claim

Outcome:

- Medicaid is payer of last resort
- Funds recovered

Shared Data/Interfaces:

- MMIS
- DSS
- CBMS

- HMS
- SSA
- CMS
- Railroad Retirement Board
- Medicare premium payments
- COFRS

To Be:

- Streamline TPL contractor recovery process
- Improve recovery tracking in MMIS
- No longer house TPL information in CBMS – place information directly into MMIS (auto or manual). MMIS should own TPL information.
- Require interface between TPL contractor and MMIS to pipe in validated TPL information
- Daily TPL processing (currently weekly)
- BENDEX / SDX / Medicare data in MMIS
- PARIS (identifies TRI-CARE recipients) data feed / reconciliation process incorporated

Failures:

- Bad data
- Interface problems (CBMS, MMIS)
- BENDEX / SDX / Medicare data feeds not in MMIS
- Inability to automatically load TPL data
- Timeliness
- TRAILS does not send TPL or Medicare data to MMIS
- Manual interface / Human error
- Time / Resources
- Data entry errors resulting in lack of matches (e.g. 'Sally' in Medicaid data, 'Sarah' in Medicare data)

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Manage Cost Settlement
Author(s): Jeremy Tipton, Elizabeth Lopez	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Hospitals, Contracted Auditor, Rates and Analysis staff, Intermediaries, Fiscal Agent, MMIS, COLD, DSS	
Description: The ***Manage Cost Settlement*** business process begins with requesting annual claims summary data. The process includes reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from hospitals, 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 loading interim reimbursement rates.	
Precondition(s): • Outpatient Hospital claims are processed • Audited Medicare Cost Report • Expenditure Summary (TAB RUN) • Interim reimbursement rates are loaded	
***Trigger*:** Receipt of the audited Medicare Cost Report	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M**	***Steps*:** 1. Start: Contract Auditor **sends** request for Expenditure Summary Report (TAB RUN) to Rates staff 2. Rates staff **submits** request to Fiscal Agent to create the Expenditure Summary Report (TAB RUN) 3. Rates staff **forwards** Expenditure Summary Report (TAB RUN) report to Contract Auditor 4. Contract Auditor **conducts** audit and determines settlement amounts 5. Contract Auditor **notifies** Hospital and Rates staff regarding settlement amount 6. Hospital **files** an appeal within 30 days, if desired (see Provider Grievance and Appeal Business Process)

	7. End: **Process** payment/recovery

***Outcome*:** Costs are reconciled to bring payments in line with the targeted percent of cost

Shared Data/Interfaces:

- MMIS
- COLD
- DSS
- COFRS
- Hospitals
- Contract Auditor
- Intermediaries

To Be:

- Increase validation of Expenditure Summary Report (TAB RUN) output
- MMIS that does prospective payments to avoid cost settlement
- Flexible reporting capabilities:
    a. Does not fail if a value is too large
    b. Rates staff has access to the reporting they need without the Fiscal Agent
    c. Ability to see information at a high-level, or drill down to details as desired
- Configurable system that reduces the need for CSRs

Failures:

- Delay in CMS decision delays cost reporting from hospitals and intermediaries
- Expenditure Summary Report (TAB RUN) does not always calculate correctly; large values and missing data can cause calculation errors in the report
- Limited validation of Expenditure Summary Report (TAB RUN) output

Notes: *No notes captured.*

OPERATIONS MANAGEMENT USE CASE	
***Business Area*:** Operations Management	***Business Process:*** Manage Drug Rebate
Author(s): Anne Martin, Shane Mofford, Greg Tanner, Yoseph Daniel, Dee Cole, Vicki Foreman, Vince Sherry, Juanita Pacheco, Jim Leonard, Anna Davis, Sarah Henderson, Sonia Sandoval, Diane Zandin, Jon Meredith	
Facilitator: Jennifer Kraft	
***Actor(s)*:** Drug Rebate Program Staff, MMIS, DSS, Drug Rebate Administrative Management System (DRAMS), PDCS, Fiscal Agent, CMS, Drug Manufacturers	
Description: The **Manage Drug Rebate** business process describes the process of managing drug rebate that will be collected from manufacturers. According to CMS, the process begins with receiving quarterly drug rebate data from CMS and includes 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.	
Precondition(s): • Rebateable drug • Enrolled clients, eligible for Medicaid • Claim is submitted and processed and “travels” from PDCS to DRAMS • NDC needs to be on a claim • Supplemental rebates are loaded	
***Trigger*:** Receipt of the CMS quarterly file by the Fiscal Agent	
Manual (M) or Automated (A) **1. A** **2. A** **3. M**	***Steps*:** 1. Start: Fiscal Agent **loads** data into DRAMS. 2. DRAMS **creates** invoices for manufacturers. 3. End: Fiscal Agent **sends** hard or softcopy invoices to manufacturers.
***Outcome*:** Drug rebate invoices are sent to the manufacturer.	

Shared Data/Interfaces:

- DRAMS
- PDCS
- MMIS
- DSS
- Fiscal Agent receives CMS quarterly file on disk

To Be:

- Improve edit ability in MMIS system to accommodate if NDC is not on claim
- Capture all drugs regardless of claims submission type
- Capture DRAMS data in DSS
- Determine if CMS quarterly file can be submitted more frequently (and electronically)
- Maintain table containing all CMS drug rebate files in MMIS and DSS to capture drug rebate history
- Procedure manual
- Trained back-up staff
- Simplify claims tracking processing
- Obtain managed care organization drug utilization information
- System tracks and reports physician administered drugs (e.g. 'J-Codes') eligible for drug rebate
- Indication on claim that the drug is rebate eligible, include rebate % if possible

Failures:

- Takes too long to get data information from Fiscal agent
- All drugs are not being captured regardless of claims submission type (includes DME, physician administered drugs)
- Quarterly data not received from CMS (or bad disk received, gets lost in mail, delivered elsewhere)
- Single point of failure – lack of knowledge transfer due to single staff member
- No feedback/traceability from internal DRAMS claims processing logic
- Currently unable to capture MCO drug utilization information
- Historical drug rebate quarterly files not readily available

Notes:
-DRAMS system works well
-Greg Tanner, Controller, responded with no additional changes needed.

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Designate Approved Services and Drug Formulary
Author(s): Anne Martin, Shane Mofford, Yoseph Daniel, Dee Cole, Vicki Foreman, Vince Sherry, Jim Leonard, Anna Davis, Sarah Henderson, Sonia Sandoval, Diane Zandin, Jon Meredith	
Facilitator: Jennifer Kraft	
***Actor(s)*:** Benefits Management Unit, Pharmacy Benefits Unit, Operations, Fiscal Agent, Data Analysis, Budget, Systems staff, PDCS, MMIS, DSS, DRAMS, External stakeholders (P&T committee, DUR board), CMS, Pricing vendor, Drug Manufacturers	
Description: The **Designate Approved Services and Drug Formulary** business process begins with a review of new and/or modified service codes (such as HCPCS and ICD-10) 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 an internal or external team(s) 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 or 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 Services and Drug Formulary.	
Precondition: ***Services and Supplies:*** • Need for service ***Formulary:*** • Receive contract offers from drug manufacturers and receive DRAMS rebate information from Fiscal Agent • Utilization analysis	
***Trigger(s)*:** • New or revised legislation • Receive codes (data) from CMS	

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- New technology and products
- New safety or clinical information

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Manual (M) or Automated (A)

1. **M**
2. **M**
3. **M**
4. **M**
5. **M**
6. **M**
7. **M**
8. **M**

1. **M**
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9. **M**

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***Steps*:**

1. Start: **Receive** list (via email with attachment in text format) of services and supplies from CMS.
2. **Route** list to review team (HCPCS 2012, benefits management team).
3. List is **reviewed** by each of the benefits managers (Example: for need for service or services that will be combined, policy changes).
4. **Send** approved list to Budget.
5. Budget **calculates** fiscal impact and identifies any statutory issues.
6. Budget **routes** through appropriate clearance process (which could be internal or external).
7. List **comes back** to benefits management for **review** to implement into system through transmittal process.
8. End: **Publish** to providers.

Alternate Steps for Formulary:

1. Start: **Review** claims utilization.
2. **Identify** areas (e.g., potentials for cost savings, inappropriate use, supplemental rebate opportunities, new products for new information – safety, etc.).
3. **Bring** information to quarterly stakeholder meetings.
4. Stakeholders **provide** clinical recommendations to process.
5. **Make** formulary decisions based on clinical recommendations and **determine** fiscal impact.
6. **Follow** internal clearance process.
7. **Cooperate** with manufacturers to set up supplemental rebate contracts.
8. **Make** PDCS system changes based on Formulary.
9. End: **Publish** to providers.

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***Outcome*:**

- Cost savings
- Availability of services and benefits for clients

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Shared Data/Interfaces:

- PDCS
- MMIS

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- DSS
- DRAMS
- Pricing vendor
- DUR vendor
- Data from CMS
- Fiscal Agent transmittal
- P&T committee – utilization analysis and market share analysis reports

To Be:

- Streamline rebate information process (getting information from Fiscal Agent)
- Adding rebate information into DSS
- 2nd pharmacist
- Interface for Drug manufacturers to directly input contract offers into system
- Receive CMS file in user-friendly format
- Application that communicates to providers and clients the changes on available products (is currently sent out via email blast)
- System feedback in claims DSS (to see if it was preferred or not preferred at the time the claim was paid)

Failures:

- Not receiving CMS report timely
- Processes are too manual/ too many man-hours
- Rebate information is not in DSS

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Manage Rate Setting
Author(s): Shane Mofford, Tim Cortez, Bonnie Kelly, Anna Davis, Joey Gallegos, Bret Pittenger, René Horton, Jon Meredith, Jeremy Tipton, Sharon Liu, Vernae Roquemore, Carol Reinboldt, Sonia Sandoval, Joel Dalzell, Sean-Casey King, Joan Welch, Karen Janulewicz	
Facilitator: Kassie Gram	
***Actor(s)*:** Providers, legislation, Department audit contractors, State staff including policy and rates group, JBC/OSPB, fiscal agent, rates information vendors (provides updates)	
Description: The **Manage Rate Setting** business process includes the activities conducted by the Department in responding to requests to add or change rates for any claim-based service or product covered by the Medicaid program.	
Precondition: A provider submits a request for reimbursement for Medicaid	
***Trigger(s)*:** • Legislature or external force (e.g., MFP grant) that asks for a new benefit or rate to be set; or according to standard process according to schedule • Regular and ad hoc events that occur based on who or what initiates the change (Federal/State/provider) For example: • CMS provides updates • Legislation action • Provider initiated • Manual pricing issues • Updates to diagnosis codes • Appeal outcomes • Provider cost change • Annual rebasing schedule based on cost report year • Nursing facility • Budget reduction ideas • Cost savings ideas • New waiver applications/amendments/renewals/state audits/evidentiary reports • New technology	

Manual (M) or Automated (A) **1. M** **2. M** **3. M/A** (pharmacy ingredient cost-monthly updates from vendor) **4. M** **5. M**	***Steps*:** 1. Start: **Review** category of service and existing reimbursement policy 2. **Determine** if benefit/rate methodology is existing or new: a. For new benefit/rate methodology: Develop policy, set rate, and receive necessary approvals of policy from external and internal stakeholders b. For existing benefit/rate methodology: Update rate according to existing policies and procedures (includes timing) 3. **Load** rates into the MMIS and **communicate** rates to stakeholders 4. **Adhere** to appeals process-provider initiated (when applicable). The appeal option is not available if on a fee schedule. Cost based rates are appealable 5. End: **Attach** rate to benefit, define other limiting criteria, and load into MMIS

***Outcome*:** Rate is updated or added

Shared Data/Interfaces:

- Pharmacy ingredient costs
- Cost reports
- Automated pharmacy rate vendor
- CMS data
- MMIS
- DSS (rate tables)

To Be:

- A system that can reference other data sources (e.g., LTC functional assessment (BUS), clinical data & electronic health records) in the MMIS to inform the setting of rates at the time of service
- Real time determination and communication
- Flexible
- Modular
- Updateable

Failures:

- No approval
- Denial of rate setting
- Delayed notification

- Rate not making it in system in time
- System limitations to implement the methodology
- Inefficient and burdensome
- Can't get hands on data
- Staff turnover
- Lack of communications
- Parallel system for encounter data does not exist
- Manual workarounds built into system
    a. For example, encounter data (logic) is put in FFS system; creates conflict between encounter claims
- System integration; e.g., UM vendor or any vendor outside of fiscal agent

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Develop and Maintain Benefit Package
Author(s): Shane Mofford, Tim Cortez, Bonnie Kelly, Anna Davis, Joey Gallegos, Bret Pittenger, René Horton, Jon Meredith, Jeremy Tipton, Sharon Liu, Vernae Roquemore, Carol Reinboldt, Sonia Sandoval, Joel Dalzell, Sean-Casey King, Joan Welch, Karen Janulewicz	
Facilitator: Kassie Gram	
***Actor(s)*:** Providers, clients, advocates, legislation, State staff including policy and rates group, JBC/OSPB, CBMS	
Description: The **Develop & Maintain Benefit Package** business process begins with the Department's 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, changes resulting from court decisions, or medical procedures or processes. 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, but not limited to: • 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 such as Medicaid managed care plans or clearinghouses.	
Precondition: Receipt of new legislation (State or Federal), budget request, and internal initiatives	
***Trigger(s)*:** • Legislature or external force (e.g., MFP grant) that asks for a new benefit or rate to be set; or according to standard process according to schedule • Regular and ad hoc events that occur based on who or what initiates the change (Federal/State/provider) For example: • CMS provides updates • Legislation action	

- Provider initiated
- Manual pricing issues
- Updates to diagnosis codes
- Appeal outcomes
- Provider cost change
- Annual rebasing schedule based on cost report year
- Nursing facility
- Budget reduction ideas
- Cost savings ideas
- New waiver applications/amendments/renewals/state audits/evidentiary reports
- New technology

Manual (M) or Automated (A)	***Steps*:**
1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M**	1. Start: **Receipt** of coverage requirements and/or recommendations identifying new or modified benefits. 2. **Procure** vendor (if necessary) 3. **Research** requirements and recommendations and identify implementation constraints 4. **Evaluate** Medicare policy against Medicaid policy to identify conflicts 5. **Make** a coverage determination 6. **Conduct** benefits collaborative process includes a. **Obtain** required stakeholder input b. **Define** and **design** the benefit package (includes talking to coding specialist to determine codes) c. **Approve, deny** or **amend** the recommendation 7. **Follow** rule making and/or State Plan Amendment process 8. End: **Attach** rate to benefit, define other limiting criteria, and load into MMIS

***Outcome*:**

- Claims are processed and paid
- Services are available to be delivered to approved providers and clients
- Benefit is added or updates made to state plan or waiver

Shared Data/Interfaces:

- Data coming in from CBMS (benefit package)
- CMS data
- BUS

- DSS

To Be:

- LTC needs to be integrated into benefits collaborative
- Infinite flexibility on which providers can bill for a service and which clients can receive a service
- Establish coverage criteria within policy (current system limitation)
- Modular, flexibility and updateable
- Repeatable consistent process
- Tools to obtain efficacy
- System integration; e.g., UM vendor or any vendor outside of fiscal agent
- Granular definition of benefits package in DSS
- Implement a way to show more accountability for providers
- Enhanced reporting

Failures:

- System limitations
- Lack of documented processes

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process***: Maintain Benefits/Reference Information
Author(s): Shane Mofford, Tim Cortez, Bonnie Kelly, Anna Davis, Joey Gallegos, Bret Pittenger, René Horton, Jon Meredith, Jeremy Tipton, Sharon Liu, Vernae Roquemore, Carol Reinboldt, Sonia Sandoval, Joel Dalzell, Sean-Casey King, Joan Welch, Karen Janulewicz	
Facilitator: Kassie Gram	
***Actor(s)*:** Providers, clients, advocates, legislation, State staff (including policy and rates group), JBC/OSPB, Fiscal Agent	
Description: The **Maintain Benefits/Reference Information** process is the maitenance or addition of any new program, change to an existing program or budgetary changes. The process includes revising code information including HCPCS, CPT, NDC, and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, and/or updating/adding member benefits	
Precondition: • Rates set and encounter data updated • Benefits are determined and rates are set	
***Trigger*:** • Set or update a fee or update a benefit package • Code changes/updates from (for example) CMS/NUBC/ICD9/NDC	
Manual (M) or Automated (A) **1. M** **2. M** **3. M/A** **4. M** **5. M** **6. M**	***Steps*:** 1. Start: **Review** codes from CMS and NUBC 2. **Conduct** transmittal process to fiscal agent 3. Fiscal Agent **updates** rates and reference files (Included hospital base rates into system) 4. **Follow** CSR process for change requests 5. **Test** changes if necessary 6. End: **Accept** and migrate
***Outcome*:** Information is updated	

Shared Data/Interfaces:

- MMIS
- Reference interfaces
    a. CMB (Lab Pricing Data)
    b. COLD (Reference Reports)
    c. DSS (Reference Data)
    d. EDI (HCPCS Data)
    e. PDCS (HCPCS NDC Data and Drug/NDC data)

To Be:

- Establish a manageable process to maintain benefits and reference information
- Identify a way to avoid being constrained by resource needs (e.g., how to adjust for the lack of certified coders working with policy)
- Document procedures to alleviate head bound knowledge
- Remove hard coding and manual workarounds
- Implement a modular system with flexible design

Failures:

- There currently is not an adequate process in place to maintain benefits and reference information
- Lack of certified coders working with policy
- Resource constraints
- Head bound knowledge
- Lack of modular, flexible design
- Antiquated system
- Backlog of CSRs

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Develop and Maintain Program Policy
Author(s): Shane Mofford, René Horton, Vernae Roquemore, Jenny Nunemacher, Jeanine Draut, Sean Bryan, Anna Davis, Jon Meredith, Sandy Salus, John Barry, Carol Reinboldt, Dee Cole, Sean-Casey King	
Facilitator: Kassie Gram	
***Actor(s)*:** Department staff, Federal and State government, stakeholders (e.g., providers, clients, advocates), other State agencies, Attorney General, Legal Division, Medical Services Board (MSB), SharePoint, MMIS, DSS, PDCS, BUS, CBMS	
Description: The ***Develop and Maintain Program Policy*** business process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as: Federal or State statutes and regulations; governing board or commission directives; Quality Improvement Organization's findings; Federal or State audits; enterprise decisions; and consumer pressure.	
Precondition(s): • Established Medicaid program goals and objectives • Department strategic plan in place • Ongoing process improvement programs (Triple Aim)	
***Trigger(s)*:** • Legislation (State and Federal) • Federal Regulatory Changes • Budget actions • Audit findings • Stakeholder pressure • Technology changes • Client need • Appeals decisions / legal action • Identification of / changes in best practices • Need for policy clarification/definition	

Manual (M) or Automated (A)	***Steps*:**
1. M/A **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M**	1. Start: Designated Department staff **monitors** various communication channels 2. Designated Department staff **determine** high-level impact on the Department 3. Designated Department staff **sends** notification to the appropriate staff 4. Department staff **interprets** impact on the stakeholders 5. Department staff **drafts** policy change and implementation plan, with internal and external stakeholder involvement 6. **Determine** if rule change/state plan amendment (SPA) are needed 7. **Determine** if significant changes to claims/payment systems are required to implement the change. 8. **Coordinate** internal clearance 9. **Request** funding and approval, if required 10. **Communicate** changes 11. End: **Implement** changes

***Outcome*:**

- New policy or policy change has been defined and implemented
- Inability to implement changes if funding not obtained
- Inability to implement changes due to system limitations

Shared Data/Interfaces:

- SharePoint
- MMIS (generates provider claim reports)
- DSS
- PDCS
- BUS
- CBMS
- Website
- Web Portal
- Email
- COFRS

To Be:

- More flexible/configurable systems
- Modular systems based on service delivery more than payment/claim type

- MMIS documentation specific to each high level service that can be reviewed each time major policy changes are made
- SOA
- Standardize process inputs
- Streamline process
- Document process
- Communication architecture
- Improved management of the long cycle

Failures:

- Designated Department staff not always notified
- Communication failures
- Stakeholder identification issues
- Staff turnover/retention
- Institutional knowledge of unique programs, regular updates, and special manual work-arounds are not documented and are managed by solo individuals, loss of such individuals leads to significant risk.
- Process not standardized/defined
- Insufficient funding
- System limitations due to antiquated MMIS
- Current MMIS is payment-type based and not grouped in a way that makes logical sense to policy-makers.
- No historical policy information
- Long cycle
- Funds appropriation
- Unrealistic timelines

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Maintain State Plan
Author(s): Shane Mofford, René Horton, Vernae Roquemore, Jenny Nunemacher, Jeanine Draut, Sean Bryan, Anna Davis, Jon Meredith, Sandy Salus, John Barry, Carol Reinboldt, Dee Cole, Sean-Casey King, Jeanine Draut	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** CMS, Legal Division, other State staff, State Plan Coordinator (Department), Tribal groups, public, stakeholders	
Description: The ***Maintain State Plan*** business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.	
Precondition: State Plan	
***Trigger(s)*:** • Identification of outdated State Plan • State Plan review • Policy change requiring State Plan Amendment • State / Federal legislation requiring state plan amendment	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M** **12. M** **13. M**	***Steps*:** 1. State Plan Coordinator **receives** notification or **identifies** that a change to the State Plan is required 2. **Identify** the pages of the State Plan that need to change. **Consult** with other Department staff, if necessary 3. **Edit** the pages with required changes 4. **Request** Transmittal Number (TN) from legal division 5. **Complete** State Plan submittal paperwork 6. **Coordinate** internal clearance 7. **Send** draft of SPA to CMS 8. **Complete** Tribal consultation 9. **Issue** public notice, if necessary 10. **Adjust** language and paperwork, as needed 11. **Receive** final Departmental clearance

14. M **15. M** **16. M** **17. M** **18. M**	12. Legal Division **submits** to CMS 13. Legal Division **receives** official response from CMS, within 90 days 14. Department staff **respond** to CMS informal request for information, if requested 15. Legal Division **responds** to CMS formal request for information with a new version of the State Plan, if requested, within 90 days and signed by the office director 16. Legal Division **receives** official response from CMS, within 90 days 17. Legal Division **updates** website with approved pages 18. **Operationalize** SPAs with MSB Rulemaking process
***Outcome*:** State Plan is maintained and current	
Shared Data/Interfaces: • Website • Tribal consult repository	
To Be: • Faster turnaround by CMS • Improved approval process – automated • Pre-approval process • Standardized process • Word Document (or other edit-able format) versions of all state plan pages, past versions included, maintained within the Department and available for editing. • A current, official electronic version of the entire state plan available to all Department staff	
Failures: • Lack of timely review by CMS • Ambiguous requirements (e.g., timely review) • Coordination of timelines between approval process and policy implementation often don't match • Missing pages, no electronic version (other than PDF scan) of many pages • Fragmented information in different sections of state plan	
Notes: *No notes captured.*	

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process***: Develop Agency Goals and Initiatives
Author(s): Julie Collins	
Facilitator: Kassie Gram	
***Actor(s)*:** Executive Committee, Leadership Team, Department Managers, Policy staff (Subject Matter Experts)	
Description: The ***Develop Agency Goals and Initiatives*** business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes or new initiatives are necessary. Changes to goals or developing new initiatives could be warranted for example, under a new administration; or in response to changes in policies, demographics, public opinion or medical industry trends; or in response to regional or national disasters.	
Precondition(s): • Established leadership to define goals and initiatives • Mission statement is defined	
***Trigger(s)*:** • Executive Order • Legislation • Scheduled review cycle (I.e., future year's strategic planning, Operational planning schedule, Mid-year progress reporting)	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M**	***Steps*:** 1. **Identify** internal subject matter experts for the initiative/strategic goals 2. **Develop** benchmarks as they relate to initiative/strategic goals 3. **Gather** historic and preliminary data as it relates to the initiative/ strategic goals 4. **Review**, **analyze** and **refine** the benchmark as necessary 5. **Submit** revised strategic plan and benchmarks to Executive Committee for review and approval 6. **Submit** Strategic Plan changes to the Governor's office for review and approval

	7. **Monitor** approved future-year benchmarks to ensure they are measureable; identify additional measurement possibilities 8. **Deliver** approved strategic plan to General Assembly on November 1 as part of the annual budget request. 9. **Post** the approved strategic plan to the Department's website

***Outcome*:** Agency goals and initiatives are established, progress is measured semi-annually, and reported annually

Shared Data/Interfaces:

- General assembly
- Published to the public Website on 11/1 every year as a required component of the annual budget request
- Publishing Governor's Office of Planning and Budgeting – Website

To Be:

- Ability to link reports to every year's strategic benchmarks
- Ad hoc reporting
- New DSS to provide consistent reporting against benchmarks
- New software platform in place for strategic and operational planning with dashboard reports for all benchmarks. For example, see Minnesota's dashboard at http://dashboard.dhs.state.mn.us/
- Enforce consistent use of standardized process for setting measureable goals; create depth of understanding
- Integrate operational and strategic goals into department job descriptions and employee performance evaluation plans to enhance accountability and employee buy-in

Failures:

- No way to automate or achieve real-time reporting on benchmark progress
- Benchmarks are set without checking if it can be measured using the MMIS (some must be measured using external or ad hoc data sources with varied reporting cycles and date spans)
- High turn-over impacts this business process due to heavy reliance on manual reporting processes and individual subject matter expertise
- There is no standardized policy that links the department strategic and operational goals to individual employee performance measures or job duties.

Notes:

Julie conducts spring workshops on defining measureable goals for key Managers and Operational planning leads. This has created some standardization of goal setting.

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process***: Manage Federal Financial Participation for MMIS
Author(s): Sandra Salus, Laurie Stephens, Juanita Pacheco, Lynn Clinton, Jon Meredith, René Horton, Jen St. Peter, Greg Tanner, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Operations and Claims Division, Accounting, Budget, CMS, Fiscal Agent, Data Section staff, Priority Change Board	
Description: The Federal government allows funding for the design, development, maintenance, and operation of a federally certified MMIS. The ***Manage Federal Financial Participation (FFP) for MMIS*** business process oversees reporting and monitoring of Advance Planning Documents and other program documents necessary to secure and maintain federal financial participation.	
Precondition: Determination of need to add or modify a program	
***Trigger(s)*:** • Change to Federal/State regulation to add a new program or change a program • Predetermined reporting date	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M**	***Steps*:** **Generating APD:** 1. Start: Legislation **adds** new benefit 2. **Complete** Project Initiation Form (PIF) to define the new program or change 3. **Receive** estimated cost from Fiscal Agent 4. **Entered** PIF information and cost estimate into APD 5. **Submit** PIF and cost estimate to the Change Board for review and prioritization 6. **Submit** APD to CMS for review and approval 7. **Receive** CMS decision 8. **Execute** contract with Fiscal Agent 9. End: **Notify** Fiscal Agent to begin work

1. M **2. M** **3. M**	**Reporting on Administration of MMIS:** 1. Start: **Assign** COFRS coding to PO or RQ to encumber funds 2. **Run** query to capture information to report on CMS 64 or CMS 21 3. End: **Generate** report

Outcome:

- Generating APD Outcome: Approved APD and executed contract
- Reporting Outcome: Reporting of expenditures and the associated FFP

Shared Data/Interfaces:

- COFRS
- MBES/CBES – online system to generate the report
- SharePoint
- State Share

To Be:

- Automate reporting
- Paperless/Electronic
- Electronic signatures and improved clearance process
- Improved coordination and standardization
- Increase the number of GL codes and make it easier to add GL codes

Failures:

- Timeliness of CMS response
- Slow and time consuming process
- Delay in starting the APD process causes delay in funds appropriation
- Lack of ability to run concurrent Federal and State approval processes
- Inadequate time allowed, lack of coordination, lack of resources and direction, from APD approval to required implementation deadline
- Lack of standardization (CMS)

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Manage Federal Financial Participation for Services
***Author(s)*:** Sandra Salus, Laurie Stephens, Juanita Pacheco, Lynn Clinton, Jon Meredith, René Horton, Jen St. Peter, Greg Tanner, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Fiscal Agent, Department staff, Providers, Legal Division, Program Integrity staff, Attorney General MFCU staff, Accounting staff, MMIS, DSS, ESUR, PDCS, COFRS, BUS	
Description: The ***Manage Federal Financial Participation (FFP) for Services*** business process applies rules for assigning the correct Federal Medical Assistance Percentages (FMAP) rate to service expenditures and recoveries documented by the Medicaid enterprise. FFP for expenditures for medical services under the Medicaid enterprise is dependent on the nature of the service and the eligibility of the beneficiary. The FMAP rate applies to Medicaid expenditures for services covered under the State Plan with the exception of things such as: • Family planning services for which FFP is 90% • Services provided through Indian Health Service facilities for which FFP is 100% • Services provided to members eligible under the optional Breast and Cervical Cancer program for which FFP is based on SCHIP Enhanced FMAP rate • Medicare Part B premiums for Qualified Individuals for which FFP is 100% unless the allotment is exceeded and then the FFP is 0% • Transportation provided per the requirements of 42 CFR431.53 for which FFP is 50% • FFP for expenditures for medical services under the SCHIP program is based on the "Enhanced Federal Medical Assistance Percentages'' (enhanced FMAP).	
Precondition: Service has been provided	
***Trigger(s)*:** • Identify need for adjustment • Receipt of notification to apply FMAP rate to service expenditures or recoveries	
Manual (M) or Automated (A) **1. M/A**	***Steps*:** 1. Start: **Receive** claim (via MMIS or entered directly into COFRS) 2. **Determine** FMAP to be applied

2. M (COFRS)/A **3. A** **4. A** **5. A**	3. **Pass** data from MMIS to COFRS through financial cycle interface 4. FMAP **assigned** through COFRS REVA process 5. End: **Generate** reports for FMAP funding requests

***Outcome*:** Service expenditure and recovery data with applied FMAP rate

Shared Data/Interfaces:

- COFRS
- MMIS
- DSS
- ESUR
- PDCS
- BUS
- CMS
- Payment Management System (PMS)

To Be:

- Ability to reconcile MMIS with COFRS
- Ability to make payments out of MMIS (to reduce number of systems involved)
- Increase automation
- Paperless
- Increase the number of GL codes and make it easier to add GL codes
- COFRS warrant numbers associated with claim numbers in MMIS

Failures:

- COFRS tables not loaded correctly
- Human Error – without understanding of claims and how they should be paid, wrong FMAP can be applied
- If GL codes are not loaded correctly, MMIS payments do not interface with COFRS correctly (and will not get paid)
- Multiple manual workarounds to associate services with proper FMAP, requires Data, Budget, and Accounting staff to complete (e.g., family planning reporting process)
- Audit findings faulting the use of manual workarounds to move expenditures between accounting / CMS reporting lines

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Formulate Budget
Author(s): Sandra Salus, Laurie Stephens, Juanita Pacheco, Lynn Clinton, Jon Meredith, René Horton, Jen St. Peter, Greg Tanner, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Budget staff, Office of State Planning and Budgeting (OSPB), Joint Budget Committee (JBC), Legislative Council	
Description: The ***Formulate Budget*** business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and periodically produces a new budget.	
Precondition(s): • Develop Agency goals and objectives • Performance measures • Policy	
***Trigger(s)*:** • Scheduled date for budget review • Notification of a revenue shortfall • Legislation	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M**	***Steps*:** 1. Start: **Receive** notification of budget action 2. Executive Committee **approves** budget action 3. **Write** and **submit** budget action to OSPB 4. **Submit** budget action to JBC 5. JBC **approves** or **denies** budget action 6. If approved, the Department's budget **receives** notification of appropriation 7. End: **Publish** updated budget

***Outcome*:** Revised budget
Shared Data/Interfaces: • COFRS • OSPB • JBC • MMIS (update GL Codes) • Open drive (internal staff information repository) • DSS • CBMS
To Be: • More flexible budget schedule • Electronic budget submission system • Complete financial management system through the DSS • DSS should be a true data warehouse • DSS should have data marts; one of the data marts should be built to Budget Office specifications for their business needs (including forecasting, financial management, etc.)
Failures: • Forecast errors • Incomplete data • Political environment • Competing priorities • Inconsistency between budget schedule and operational needs • Systematic discrepancies between the MMIS/DSS and COFRS • Not all caseload data captured in MMIS
Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Manage State Funds
Author(s): Sandra Salus, Laurie Stephens, Juanita Pacheco, Lynn Clinton, Jon Meredith, René Horton, Jen St. Peter, Greg Tanner, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Accounting staff, Budget staff, Legislature, COFRS, State Auditors	
Description: The ***Manage State Funds*** business process oversees Medicaid State funds and ensures accuracy in the allocation of funds and the reporting of funding sources. Funding for Medicaid services may come from a variety of sources, and often State funds are spread across State agency administrations such as Mental Health, Aging, Substance Abuse, physical health, and across State counties and local jurisdictions. The Manage State Funds monitors State funds through ongoing tracking and reporting of expenditures and corrects any improperly charged expenditures of funds. It also deals with projected and actual over and under allocations of funds.	
Precondition: Formulated budget	
***Trigger(s)*:** • Legislation is passed • Scheduled reporting	
Manual (M) or Automated (A) **1. M/A** **2. M** **3. M** **4. M/A** **5. M** **6. M**	***Steps*:** 1. Start: **Record** budget in COFRS 2. State Controllers Office **approves** the budget 3. **Establish** coding in MMIS/COFRS 4. **Complete** expenditures 5. **Monitor** and **analyze** expenditures 6. End: **Perform** adjustments through internal review or audit, as needed

***Outcome*:**

- Expenditures are recorded correctly
- Expenditures are tracked, monitored, and adjusted when necessary

Shared Data/Interfaces:

- COFRS
- MMIS
- SQL (Points to COFRS)
- Financial Data Warehouse (Points to COFRS)
- Document Direct (Points to COFRS)

To Be:

- ERP system
- Increase the number of GL codes and make it easier to add GL codes
- Complete financial management system through the DSS
- DSS should be a true data warehouse
- DSS should have data marts; one of the data marts should be built to Budget Office specifications for their business needs (including forecasting, financial management, etc.)

Failures:

- Human error – too many manual processes
- Inflexibility of systems
- Inability to automate
- Lack of budget/funding
- Time and resources

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Manage 1099s
Author(s): Sandra Salus, Laurie Stephens, Juanita Pacheco, Lynn Clinton, Jon Meredith, René Horton, Jen St. Peter, Greg Tanner, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** State Controller's Office, COFRS, Accounting staff, vendors, providers	
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 Federal Tax ID Number. The ***Manage 1099s*** process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. 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.	
Precondition: Vendor/Provider entity that meets 1099 criteria	
***Trigger*:** Receipt of W-9	
Manual (M) or Automated (A) 1. **M** 2. **M/A** 3. **A** 4. **M** 5. **M/A**	***Steps*:** 1. Start: **Establish** or **modify** vendor/provider record in COFRS 2. Vendor/Provider **receives** payment for goods or services 3. State Controller's Office **runs** calendar year end 1099 process 4. Accounting staff **reviews** 1099 report and applies corrections as necessary 5. End: State Controller's Office **produces** and **delivers** 1099 forms
***Outcome*:** 1099 forms are created and delivered	
Shared Data/Interfaces: • COFRS (Payment information) • W-9 (IRS Information) • MMIS (Payment information)	

- IRS

To Be:

- Vendors / Providers to keep their information current
- Current / updated provider information entered into MMIS
- Allow vendors/providers to access/retrieve 1099 (e.g., Web Portal or State website)
- Online provider enrollment
- Electronic signature
- Automate the manual 1099 review process
- Electronic interface with IRS and Secretary of State office for vendor / provider validation

Failures:

- Incorrect addresses for delivery
- Human error – fill out the W-9 incorrectly
- Manual process – data entry errors
- Volume of 1099s to be reviewed manually
- Lack of resources to research returned 1099s

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** **P**erform Accounting Functions
Author(s): Sandra Salus, Laurie Stephens, Juanita Pacheco, Lynn Clinton, Jon Meredith, René Horton, Jen St. Peter, Greg Tanner, Sean Bryan	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Accounting staff, State Controller's Office, CMS, State staff, MMIS, COFRS, State Treasury, DSS, PMS	

Description:

Currently States use a variety of solutions including outsourcing to another Department or use of a COTS package to ***Perform Accounting Functions***. Activities included in this process can be as follows:

- Periodic reconciliations between MMIS and the system(s) that performs accounting functions
- Assign account coding to transactions processed in MMIS
- Process accounts payable invoices created in the MMIS
- Process accounts payable invoices created in Accounting System (gross adjustments or other service payments not processed through MMIS, and administrative payables)
- Load accounts payable data (warrant number, date, etc.) to MMIS
- Manage canceled/voided/stale dated warrants
- Perform payroll activities
- Process accounts receivable (estate recovery, co-pay, drug rebate, recoupment, TPL recovery, and Member premiums)
- Manage cash receipting process
- Manage payment offset process to collect receivables
- Develops and maintain cost allocation plans
- Manages draws on letters of credit
- Manages disbursement of federal administrative cost reimbursements to other entities
- Respond to inquiries concerning accounting activities

Precondition: Financial activity

***Trigger(s)*:**

- Managing AP / AR
- Maintaining financial data
- Monitor and analyze expenditures and cash receipts to fulfill internal reporting needs
- Required State / Federal reporting

Manual (M) or Automated (A)	***Steps*:**
1. M/A **2. M/A** **3. M** **4. M/A**	1. Start: **Receive** notice of financial activity 2. **Generate** financial transaction in COFRS (includes payment and deposit activities) 3. **Monitor** and **analyze** financial activity 4. End: **Produce** reports

***Outcome*:**

- Financial activity is recorded
- Financial reports are generated

Shared Data/Interfaces:

- COFRS
- MMIS
- DSS
- Financial Data Warehouse
- Document Direct
- COLD
- CMS
- PMS
- SQL

To Be:

- ERP System
- Ability to reconcile MMIS with COFRS
- Associate COFRS warrant numbers with specific claims in MMIS / DSS
- Load financial data such as journal vouches (jv) and payment vouchers (pv) in the MMIS / DSS
- Ability to make payments out of MMIS (to reduce number of systems involved)
- Increase automation
- Paperless
- Increase the number of GL codes and make it easier to add GL codes
- Complete financial management system through the DSS
- DSS should be a true data warehouse
- DSS should have data marts; one of the data marts should be built to Budget Offices specifications for their business needs (including forecasting, financial management, etc.)

Failures:

- Manual processes result in human error
- Lack of automation
- Limited GL codes
- COFRS is antiquated and not user friendly
- Difficult – sometimes impossible – to balance COFRS and the MMIS
- Multiple negative audit findings

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Develop and Manage Performance Measures and Reporting
Authors: Nathan Culkin, Sandra Salus, Dee Cole, Sharon Brydon, Beth Martin, John Aldag, Taylor Larsen, Jen St.Peter, Michael Sajovetz, Katie Brookler, Jon Meredith, Rene Horton, Lynn Clinton, Dan Rodriguez, Jerry Smallwood, Jerry Ware	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** CMS, Fiscal Agent, Contractors, Legislature, Providers, County workers, public, Website, TRAILS, MMIS, DSS, CDPHE, DHS, DBH, the Department, CBMS, State immunization registry	

Description:

The ***Develop and Manage Performance Measures and Reporting*** process involves the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise's processes and programs. This includes the steps involved in defining the criteria by which activities and programs will be measured and developing the reports and other mechanisms that will be used to track activity and effectiveness.

Some categories of performance measures for the Colorado Medicaid program include:

- HCBS Performance Measures (Fed)
- BHO Performance Measures (State)
- Balanced Scorecard
- HEDIS Performance Measures
- CHP+ Performance Measures (overlap BHO and Balanced Scorecard, which are reported to CMS)
- Healthy Living measures
- Supply sensitive measures
- Preference sensitive measures
- ARRA Prompt Pay Reporting
- Grant specific reporting
- MEQC and PERM
- PARIS

Precondition: Defining the agency goals and objectives.

***Trigger(s)*:**

- Receive a request to revise an existing performance measure, develop a new performance

measure, or adopt a national standard.
- Establish a new program or service delivery system.
- Legislation that requires reporting.

Manual (M) or Automated (A)	***Steps*:**
1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M** **12. M**	1. Start: **Identify** need for program performance measurement 2. **Research** existing performance measures - their definitions, calculation, methodology, and data availability 3. **Determine** which performance measures fit the need 4. **Develop** State specific performance measures, as necessary 5. **Establish** reporting methodology and frequency of performance measurement 6. **Calculate** baseline for performance measure and distribute reports a. Integrate non-administrative data 7. **Conduct** peer review 8. **Revise** performance measure, as necessary 9. **Run** the final calculation 10. **Conduct** peer review 11. **Coordinate** clearance process, if necessary 12. End: **Distribute** results to appropriate stakeholders - State, federal, public, website, contractors (Fiscal Agent/call center, enrollment broker, etc.)

***Outcome*:** Performance measures and reporting schedule have been established and are operational.

Shared Data/Interfaces:

- MMIS
- DSS
- CBMS
- Website
- Immunization Registry
- Provider medical records
- BUS
- BRFSS (CDPHE - Behavioral Risk Factor Survey)
- CCAR (CO Client Assessment Review)
- MHSIP
- YSS
- YSS-F

- SDAC
- PDCS
- TRAILS
- Spyder
- AHRQ

To Be:

- Capture clinical data
- EHR (HIE)
- CO HIX
- BUS interface
- Bi-directional interface between BUS and CBMS
- Bi-directional interface between CBMS and MMIS
- New BUS
- BUS integrated into MMIS
- New MMIS
- New DSS (true data warehouse with data marts)
- Improved integration of data - TRAILS and CBMS to MMIS
- Incorporation of other datasets into MMIS / DSS (i.e. COFRS, BENDEX, SDX, etc.)
- Access to external data sources: vital statistics, DORA, State Demographer's Office
- Improved integration of PDCS data and MMIS
- Automated reporting to CMS
- Automated extract to the all payers claims database
- Real-time data (near time)
- Real-time notification of services immediately before they are used (ER and Hospitalization)
- Ability to risk adjust the data
- Geocoding and mapping capabilities integrated with DSS
- Front-end statistical software (e.g. SAS, SPSS) with direct access to DSS, enables the use of pre-existing code and programs (e.g. AHRQ's PQIs and PDIs)

Failures:

- Data availability
- Data timeliness
- Data format
- Cost – CSRs, purchasing data, and Vital Statistics
- Staff availability / resource constraints
- Privacy concerns (Vital Statistics)
- Clear management decisions and directives
- Limited integrated mapping capabilities, no geocoding capability

• Limited access to specialized software to prepare and report measures (e.g. statistical and mapping software)
Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Monitor Performance and Business Activity
Authors: Nathan Culkin, Sandra Salus, Dee Cole, Sharon Brydon, Beth Martin, John Aldag, Taylor Larsen, Jen St.Peter, Michael Sajovetz, Katie Brookler, Jon Meredith, Rene Horton, Lynn Clinton, Dan Rodriguez	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** CMS, Fiscal Agent, Contractors, Legislature, providers, County workers, public, Website, CDPHE, DHS, DBH, the Department, State immunization registry, TRAILS, MMIS, DSS, CBMS	
Description: The ***Monitor Performance and Business Activity*** process utilizes the mechanisms and measures that were developed by the ***Develop and Manage Performance Measures and Reporting*** process. The process includes the steps involved in implementing the mechanisms and measures to track agency activity and effectiveness at all levels of monitoring.	
Precondition: Develop and manage performance measures.	
***Trigger*:** Review of scheduled performance measure reporting.	
Manual (M) or Automated (A) 1. **M** 2. **M** 3. **M** 4. **M** 5. **M**	***Steps*:** 1. Start: **Calculate** baseline for performance measure and **distribute** reports a. Integrate non-administrative data 2. **Conduct** peer review 3. **Compare** rates with other data sources 4. **Revise** performance measure if necessary 5. End: **Distribute** results of reviews/validations, as necessary a. If positive, findings are communicated b. If out of compliance, corrective action is required i. Activity to be performed is identified ii. Completion of activity is assessed iii. If incomplete, Department staff determine appropriate action

***Outcome*:** Performance measures are reviewed and appropriate actions are taken.

Shared Data/Interfaces:

- MMIS
- DSS
- CBMS
- Website
- Immunization Registry
- Provider medical records
- BUS
- BRFSS (CDPHE - Behavioral Risk Factor Survey)
- CCAR (CO Client Assessment Review)
- MHSIP
- YSS
- YSS-F
- SDAC
- PDCS
- TRAILS
- Spyder
- AHRQ

To Be:

- Ability to risk adjust the data
- Independent verification of data
- Improved CPT coding for clinical data
- LOINC coding
- Ability to import into MMIS/DSS lab result data from lab processing centers (in state)
- Import any external data at will into MMIS/DSS
- Inclusion of performance standards in contracts
- Improved process for maintaining data reliability
- Automatic notification/verification of change in client circumstance from other agencies (e.g. Dept of corrections)
- Process to check for data conflicts
- Resolution process for data conflicts
- New MMIS
- New DSS
- Incorporation of other datasets into MMIS / DSS (e.g. COFRS, BENDEX, SDX, etc.)
- Access to external data sources: vital statistics, DORA, State Demographer's Office
- Geocoding and mapping capabilities integrated with DSS

- Front-end statistical software (e.g. SAS, SPSS) with direct access to DSS, enables the use of pre-existing code and programs (e.g. AHRQ's PQIs and PDIs)

Failures:

- Availability of reporting system
- Lack of contractual agreements related to performance measures
- Recipient disputing the number
- Lack of ability to risk adjust the data
- Data lacks credibility with contractors
- Use of ICD-9 code 799.9
- Inconsistent data sources create conflicts in data
- Change client circumstance affecting eligibility not reported
- Limited integrated mapping capabilities, no geocoding capability
- Limited access to specialized software to prepare and report measures (e.g. statistical and mapping software)

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Manage Program Information
Authors: Nathan Culkin, Sandra Salus, Dee Cole, Sharon Brydon, Beth Martin, John Aldag, Taylor Larsen, Jen St.Peter, Michael Sajovetz, Katie Brookler, Jon Meredith, Rene Horton, Lynn Clinton, Dan Rodriguez, Jerry Smallwood, Jerry Ware	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** State staff, Fiscal Agent, Providers, Public, Legislature, Auditors, MMIS, DSS, CMS, OSPB, CBMS, TRAILS, BUS, SDAC	
Description: The ***Manage Program Information*** business process is responsible for managing all the operational aspects of the MMIS/DSS, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions. The MMIS/DSS receives requests to add, append, replace, or change data in program records. The MMIS/DSS validates data upload requests, applies instructions, and tracks activity. The MMIS/DSS provides access to payment records to other Business Area applications and users through communication vehicles such as batch record transfers, responses to queries, and "publish and subscribe" services.	
Precondition(s): • Establish Medicaid program and daily operations • Weekly load of DSS is successful • Daily and monthly CBMS updates to MMIS are successful • MMIS accepts claims and adjudicates daily and processes weekly • PDCS daily updates to MMIS are successful • Daily cross-over claims from CMS/Medicare load successfully • Weekly TPL files from CBMS to MMIS load successfully • Manual updates (by Fiscal Agent or the Department staff) to records in MMIS processed successfully • System generated update processes run successfully	

***Trigger(s)*:**

- Need for program information
- Need to change information
- Addition of new programs
- Federal and State reporting requirements
- Contract reporting requirements
- External data requests
- Requests for data by other department agencies (e.g., DHS)
- Litigation
- Requests from Legislation

Manual (M) or Automated (A)	***Steps*:**
1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M**	1. Start: **Receive** a request for information 2. **Determine** feasibility (data availability and level of effort) and HIPAA compliance of request 3. **Develop** a project plan to complete the request 4. **Execute** project plan 5. **Document** request, plan, assumptions, and methodology 6. **Draft** report 7. **Conduct** peer review 8. **Coordinate** clearance process, if needed 9. **Distribute** the information 10. End: **Modify** reports and redistribute if needed

***Outcome*:** Requests for data are fulfilled.

Shared Data/Interfaces:

- Maximus
- MMIS
- DSS
- COFRS
- CBMS
- TRAILS
- COBA
- PDCS
- BUS
- COLD Reports
- CMS

- HEDIS
- BHO Flat Files
- NEMT Flat Files
- HMS
- Spyder
- AHRQ

To Be:

- New DSS (true data warehouse with data marts)
- New BUS
- New MMIS
- Bi-directional interface between BUS and CBMS
- Bi-directional interface between CBMS and MMIS
- Complete Medicare data
- Interfaces with external data sources
- Secured data delivery system including capacity for large volumes of data (sFTP)
- Interfaces between contractors and external data sources
- All reporting should happen out of DSS
- Improved reporting capability, ability for ad hoc reporting
- Ability to risk adjust the data
- External role based access to reports and information
- Incorporation of other datasets into MMIS / DSS (e.g. COFRS, BENDEX, SDX, etc.)
- Access to external data sources: vital statistics, DORA, State Demographer's Office
- Geocoding and mapping capabilities integrated with DSS
- Front-end statistical software (e.g. SAS, SPSS) with direct access to DSS, enables the use of pre-existing code and programs (e.g. AHRQ's PQIs and PDIs)

Failures:

- Files don't load successfully to MMIS
- Data is not available
- High level of effort to retrieve data
- Inaccurate data
- Privacy concerns (Vital Statistics)
- Limited integrated mapping capabilities, no geocoding capability
- Limited access to specialized software to prepare and report measures (e.g. statistical and mapping software)

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
Business Area: Program Management	***Business Process:*** Generate Financial and Program Analysis/Report
Author: Nathan Culkin, Sandra Salus, Dee Cole, Sharon Brydon, Beth Martin, John Aldag, Taylor Larsen, Jen St.Peter, Michael Sajovetz, Katie Brookler, Jon Meredith, Rene Horton, Lynn Clinton, Dan Rodriguez, Jerry Smallwood, Jerry Ware	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Accounting staff, Data staff, Budget staff, CMS, Fiscal Agent, Auditors, MMIS, COFRS, DSS	

Description:

It is essential for Medicaid agencies to be able 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 and Federal reporting requirements.

The ***Generate Financial & Program Analysis/Report*** process begins with a request for information or a timetable for scheduled correspondence. The process includes:

- Defining the required reports format, content, frequency and media, report's retention, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy)
- Retrieving data from multiple sources
- Compiling the retrieved data
- Formatting into the required data set

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.

Precondition(s):

- Claims have been processed
- Data sent to COFRS

***Trigger(s)*:**

- Legislation
- Legislative requests
- Business requirement
- CMS reporting requirements

- Budget requests
- Audits
- Scheduled reporting
- Department valued partners and stakeholders
- Receipt of Medicare Buy-in transaction file from CMS

Manual (M) or Automated (A)	***Steps*:**
1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M**	1. Start: **Receive** a request or run scheduled reporting 2. **Define** parameters 3. **Match** MMIS data with COFRS 4. **Move** data in COFRS, if necessary 5. **Allocate** the Federal match 6. **Pass** data from MMIS to COFRS through financial cycle interface 7. **Assign** FMAP through COFRS REVA process 8. **Run** query to capture information to report on CMS 64 or CMS 21 9. End: **Generate** reports for FMAP funding requests

***Outcome*:** Reports are generated and distributed.

Shared Data/Interfaces:

- COFRS
- MMIS
- DSS
- CMS

To Be:

- Payment out of the MMIS
- Accurate reporting of payments
- More flexible budget schedule
- Electronic budget submission system
- Complete financial management system through the DSS
- DSS should be a true data warehouse
- DSS should have data marts; one of the data marts should be built to Budget Office specifications for their business needs (including forecasting, financial management, etc.) Ability to easily replace bad data

Failures:

- Inability to create GLs, modify financial codes
- Access to data
- Manual process
- Human error
- Bad data from CMS

Notes: *No notes captured.*

PROGRAM MANAGEMENT USE CASE	
***Business Area*:** Program Management	***Business Process:*** Draw and Report FFP
Authors: Greg Tanner, Juanita Pacheco	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Accounting staff, Fiscal Agent, CMS, COFRS, MMIS, DSS, CBMS, MBES/CBES, PMS,	
Description: The ***Draw and Report FFP*** business process involves the activities to assure that federal funds are properly drawn and reported to CMS. The state is responsible for assuring that the correct FFP rate is applied to all expenditures in determining the amount of federal funds to draw. When CMS has approved a State Plan, it makes quarterly grant awards to the state to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the state to draw federal funds as needed to pay the federal share of disbursements. The state receives federal financial participation in expenditures for the Medicaid and SCHIP programs. CMS can decrease grant awards because of an underestimate or overestimate for prior quarters. Payment of a claim or any portion of a claim for FFP can be deferred or disallowed if CMS determines that the FFP claim is incorrectly reported or is not a valid Medicaid or SCHIP expenditure.	
Precondition: Expenditures	
***Trigger*:** Submit CMS 37 Medicaid or 21B CHP+ for budget through the MBES/CBES.	
Manual (M) or Automated (A) **1. M** **2. A** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M**	***Steps*:** 1. **Review** the quarterly grant request 2. **Receive** the grant award from CMS, via PMS deposits of funds into the Medicaid account, based upon the CMS 37 estimates 3. **Determine** the federal share of current expenditures, taking into consideration receipts (e.g. estate recovery, recoupments of incorrect billings), and **draw** federal funds in accordance with the terms of the Cash Management Improvement Act. 4. **Submit** Form CMS–64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program Title XIX) and Form CMS–21 (Quarterly State Children's Health Insurance Program

	Statement of Expenditures for title XXI) through the MBES/CBES. 5. **Complete** cash management reconciliation at end of each quarter using the Federal Financial Report from PMS. 6. CMS **performs** a reconciliation, and based on this, may apply adjustments to current grant and give more or take from the grant request amount already deposited, according to the resolution of issues process. The Medicaid Enterprise sends supporting documentation to the CMS Regional Office for use in their quarterly review to support MMIS numbers and to address deferrals/disallowances/supplementals. 7. **Cooperate** with CMS reviews of program and administration expenditures and implement corrective action(i.e. disallowance or deferral) if CMS' Financial Management Review (FMR) or Office of Inspector General reviews reveal any problems with respect to compliance with any federal requirement. 8. Office of State Auditor (OSA) staff **performs** annual audit in accordance with the provisions of OMB Circular A-133. 9. End: **Follow up** and **take corrective action** on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan.
***Outcome*:** • Reconciliation • Certification of the CMS-64, CMS-21, and FFR	
Shared Data/Interfaces: • COFRS • MMIS • DSS • PMS • MBES/CBES • CBMS • Transfer of data to OSA secure website – audit process	
To Be: • New accounting system • Flexible and adaptable MMIS, including payment system • Automated reporting, including CMS required reports • Analysis and audit functions in MMIS	

• Ability to quickly, easily, and cost-effectively generate new GL codes
Failures: • Lack of guidance from CMS • Not being able to change the GL to match the federal year and the federal reports – MMIS limitation • Internal communication • COFRS limitations and age – other departments use COFRS • Manual workarounds required to move funds from one accounting line to another
Notes: *No notes captured.*

CARE MANAGEMENT USE CASE	
***Business Area*:** Care Management	***Business Process:*** Manage Medicaid Population Health
Authors: Katie Mortenson, Vernae Roquemore, Laurie Stephens, Jon Meredith, Lisa Waugh, Tim Cortez, Aniss Sahli, Bret Pittenger, René Horton, Kara Ann Donovan, Gina Robinson	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** All stakeholders who have an interest in community health	
Description: This business process designs and implements strategy to improve general population health by targeting individuals by cultural, diagnostic, or other demographic indicators. The inputs to this process are census, vital statistics, immigration, and other data sources. This business process outputs materials for: ■ Campaigns to enroll new members in existing program ■ New program areas, services, etc. ■ Updated Benefits/Reference, Member, Provider ■ Communications with Impacted Members, Providers, and Contractors (e.g., program strategies and materials, etc.)	
Precondition: Interest in improving community health.	
***Trigger*:** • Population of interest in need of health improvement, services, education, intervention, etc. • Health initiatives/promotions • Policy changes • Process improvement • Problem identified with current process • Benefit expansion initiatives • Health promotion to existing population	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M**	***Steps*:** 1. Start: **Obtain** stakeholder input 2. **Identify** target areas/groups 3. **Determine** most effective way to provide information 4. **Determine** area of state with high eligible, but not enrolled, population 5. End: **Provide** the information

***Outcome*:**

- Identification of risk indicators
- Healthier population

Shared Data/Interfaces:

- CDPHE
- CDC
- Individual surveys of specific populations (i.e., CAHPS)
- Census data
- Vital stats (birth and death data)
- State and national surveys
- Internal and external stakeholders
- Local public health departments
- County commissioners
- Schools

To Be:

- Sharing data
- Access to data in a timely manner
- Ability to identify Medicaid population within data sets
- Multilingual
- Electronically communicate with clients in the community (e.g., text, mobile access, email)

Failures:

- No access to accurate demographics for sub-populations, including Medicaid
- Lack of outreach and education tools
- Coordination between State agencies and within State agencies
- Stakeholder management and engagement
- Inability to identify the right populations
- Inability to address population health, including identification of sub-groups
- Lack of cultural competency

Notes: *No notes captured.*

CARE MANAGEMENT USE CASE	
***Business Area*:** Care Management	***Business Process:*** Establish Case
Authors: Katie Mortenson, Vernae Roquemore, Laurie Stephens, Jon Meredith, Lisa Waugh, Tim Cortez, Aniss Sahli, Bret Pittenger, René Horton, Kara Ann Donovan, Gina Robinson	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Client, family members, provider, case managers, case management agencies, Department staff, other agencies (e.g., DOE, DHS), nursing facilities, home health agencies, physician offices, HCBS providers, community orgs, advocacy agencies, MMIS, DSS, BUS, CBMS, CCMS, Fiscal Agent, CMS, PPL	

Description:

The Care Management, ***Establish Case*** business process uses criteria and rules to identify target members for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication, follow-up if care was received and notify those who have not accessed care about the availability of care for those 20 and under or pregnant women of all ages.

A case may be established for one an individual in a target population such as:

- Medicaid Waiver program case management
  Home and Community-Based Services
  Other
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

Each type of case is driven by state-specific criteria and rules, different relationships, and different data.

Precondition(s):

- Financial eligibility has been determined
- Medicaid - Need for care
- Eligibility for EPSDT

***Trigger(s)*:** • Referral from nursing homes, counties, hospitals, relatives, community based orgs, etc. (happens before or after eligibility determination) • EPSDT sends a referral to a county, contractor, parent or provider based on information gathered	
Manual (M) or Automated (A) **1. M** **2. M** **3. M** **4. M** **5. M** **6. M**	***Steps*:** **All (except EPSDT):** 1. Start: **Schedule** the assessment 2. Case Management agency **performs** initial assessment to determine if applicant might meet functional eligibility 3. Case Manager **is assigned** to applicant 4. Case Manager **conducts** assessment, which includes functional eligibility and targeting criteria determination (to meet LOC for LTC programs) 5. **Determine** financial and functional eligibility a. For DD, developmental disability is determined b. SSI denial letter from Social Security for children's waiver (financial eligibility is not determined) 6. Based on client's choice and appropriateness, Case Manager **selects** appropriate program
Nursing Facility: **1. M** **2. M** **3. M** **4. M**	**Nursing Facility:** 1. **Submit** Prior Authorization request (form 5615) 2. **Administration** of PASRR (Pre Admission Screening and Resident Review) Level I (and Level II if required) 3. **Submit** for review and approval to the Long Term Care Utilization Review Contractor 4. End: If approved, client **enters or remains** in nursing facility under Medicaid
HCBS: **1. M** **2. M** **3. M** **4. M** **5. M** **6. M**	**HCBS**: 1. Case Manger **develops** service plan with client and family 2. Client **is given** choice of HCBS supports 3. Case Manager **provides** client with provider choices that meet service needs 4. Client **selects** providers 5. Case Manager **arranges for** providers to begin providing care 6. End: Case Manager **completes** Prior Authorization process (note: there is variation in who approves)

PACE: **1. M** **2. M** **3. M**	**PACE**: 1. Case Manger **develops** service plan with client and family 2. If client chooses PACE program, Case Manager **refers** client to local PACE program 3. End: PACE program **completes** enrollment
LT Home Health: **1. M** **2. M** **3. M** **4. M** **5. M**	**LT Home Health:** 1. Home health agency or SEP **receives** referral 2. Home health agency **develops** Plan of Care 3. **Send** Plan of Care to case management agency for review 4. **Respond** to questions about the medical necessity of services presented in the care plan, as necessary 5. End: Case management agency **completes** and **approves** Prior Authorization
CDASS: **1. M** **2. M** **3. M** **4. M** **5. M**	**CDASS:** 1. Client **identifies** attendants 2. PPL **trains** and **hires** attendants 3. Case Manager **completes** task worksheet and determines allocation 4. Case Manager **completes** consumer directed service plan 5. End: **Approve** service plan
EPSDT: **1. M** **2. M**	**EPSDT:** 1. Client **qualifies** for EPSDT (program is automatically available to financial eligible Medicaid clients that are 20 years old or under, or if pregnant) 2. Department **notifies** clients of available services as necessary 3. Physician **performs** standard wellness check, or additional services as necessary (EPSDT screen) 4. End: Department **assigns** EPSDT Family Health Contractor as necessary
***Outcome*:** • Client is successfully enrolled in the program, and receives appropriate care in a timely manner • EPSDT outcomes: 80% of the children eligible for Medicaid have well child check and two oral health care visits within each Federal fiscal year	
Shared Data/Interfaces: • MMIS • DSS	

- BUS
- CBMS
- CCMS
- CMS
- PPL
- ASPEN
- COLD
- New EPSDT data system

To Be:

- Disease management program
- Catastrophic cases program
- Population management program
- Interface between BUS and SAMS (older adult)/CCMS (DD), or common LTC Case Management platform (regardless of funding stream)
- Interface between LTC Case Management platform and MMIS/DSS
- Interface with BUS and CBMS and/or Health Information Exchange
- Resource support for BUS or new Case Management system
- Workflow for Case Management process
- Improved ad hoc reporting capabilities
- Automated prompts to Care Managers (ticklers)
- Less subjective assessment and care planning process, supported by a robust Care Management System – leading to standardization of assessment and care planning processes
- PACE encounters
- System integrated, internal performance measures
- Satisfaction surveys for clients, with results available in DSS
- Provide access to a new database for EPSDT

Failures:

- BUS does not communicate any other system (various systems contain same data)
- Business resources needed to manage BUS
- Lack of workflow for Case Management process
- Unable to use case management system for Meaningful Use (can't track client trends in functional abilities)

Notes:

- PPL = Public Partnership LLC
- CCMS (generates PARs for DDD)

CARE MANAGEMENT USE CASE	
***Business Area*:** Care Management	***Business Process:*** Manage Case
Authors: Katie Mortenson, Vernae Roquemore, Laurie Stephens, Jon Meredith, Lisa Waugh, Tim Cortez, Aniss Sahli, Bret Pittenger, René Horton, Kara Ann Donovan, Gina Robinson	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Client, family members, provider, case managers, case management agencies, Department staff, other agencies (e.g., DOE, DHS), nursing facilities, home health agencies, physician offices, HCBS providers, Community orgs, Advocacy agencies, MMIS, DSS, BUS, CBMS, CCMS (generates PARs for DDD), Fiscal Agent, CMS, PPL	

Description:

The Care Management ***Manage Case*** business process uses State-specific criteria and rules to ensure appropriate and cost-effective medical care; medically related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as:

- Medicaid Waiver program case management
- Home and Community-Based Services
- Other agency programs
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

These are individuals whose cases and treatment plans have been established in the ***Establish Case*** business process.

It includes activities to confirm delivery of services and compliance with the plan. It also includes activities such as:

- Service planning and coordination
- Referrals for medical and non medical services
- Brokering of services (finding providers, establishing limits or maximums, etc.)
- Facilitating/Advocating for the member
- Monitoring and reassessment of services for need and cost effectiveness. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs.

Precondition: Eligibility for programs and the initial treatment plan have been established (except for EPSDT).

***Trigger(s)*:**

- Treatment plan has been approved, and/or change in condition has been identified
- Acute care episode
- Regularly scheduled review
- EPSDT eligibility

Manual (M) or Automated (A)	***Steps*:**
	HCBS:
1. M **2. M** **3. M**	1. Start: **Perform** review of treatment plan according to established rules 2. **Update** or **conduct** new functional assessment, if necessary 3. If change in condition requires a change in treatment plan, Case Manager will **revise** the service plan and the Prior Authorization request, as required
4. M	*Service Monitoring (continuous process)* 4. End: Case Manager **follows** HCBS QIS protocols for service monitoring
	PACE:
1. A	1. Start/End: PACE program **performs** reviews and monitoring according to their established protocol and procedures
	LT Home Health:
1. M **2. M** **3. M** **4. M** **5. M**	1. Start: Home health agency staff and case manager **performs** reviews and monitoring according to their established protocol and procedures 2. **Identify** needed change to service plan 3. **Obtain** physician's order 4. **Submit** necessary service plan changes to the case management agency to review, negotiate if necessary, approve and send update to fiscal intermediary for processing 5. Case management **obtains** PAR approval and number from fiscal intermediary and forward approved PAR number to the provider to initiate/modify services
6. M **7. M**	*As needed Service Monitoring:* 6. Case Manager **responds** to client grievances, as necessary 7. End: Case Manager **responds** to indications that home health agency is unable to meet client needs
	CDASS:
	1. Start: **Perform** review of treatment plan according to established

1. M **2. M** **3. M** **4. M** **5. M** **1. M** **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M**	rules 2. **Update** functional assessment, if necessary 3. If change in condition or change in treatment plan is warranted, Case Manager will **revise** the service plan and the Prior Authorization request *Service Monitoring (continuous process)* 4. Case Manager **follows** HCBS QIS protocol for service monitoring 5. End: **Monitor** client's ability to manage their budget **EPSDT:** 1. Start: Family Health Coordinator **initiates** contact with the clients to educate them about benefits (based on either review of the COLD report or by receiving a call from the client or provider) 2. Family Health Coordinator **addresses** any issues or concerns brought up during the contact 3. Family Health Coordinator **monitors** the 2160 COLD report to determine eligible clients who have not received services (quarterly) 4. Family Health Coordinators **contact** the clients on the report 5. Family Health Coordinators **find** resources in the community (providers) 6. Family Health Coordinators **conduct** community outreach (food banks, domestic violence, etc.) 7. Family Health Coordinators **conduct** client outreach 8. Family Health Coordinators **assist** client with medical and non-medical case management 9. Family Health Coordinators **conduct** missed appointment follow-up 10. End: Family Health Coordinator **works** with other federally funded public health programs, as required
***Outcome*:** Client receives or continues to receive appropriate care in a timely manner.	
Shared Data/Interfaces: • MMIS • DSS • BUS • CBMS • CCMS • CMS	

- PPL
- ASPEN
- COLD
- New EPSDT data system

To Be:

- Hospitalization, ER visit, new chronic condition, multiple chronic conditions, etc. trigger alert to case manager
- Care coordination for all children and pregnant women regardless of health status
- Less subjective assessment process and care planning process, supported by a robust Care Management System – leading to standardization of assessment and care planning processes to include those who do not have special health care needs
- PACE encounters
- System integrated, internal performance measures
- Satisfaction surveys for clients, with results available in DSS
- Interface between Case Management Software and MMIS/DSS
- Disease management program
- Catastrophic cases program
- MMIS needs to be able to support the EPSDT program (regardless of the department that may run the program
- Real-time data reporting

Failures:

- Case Managers authorize more services than needed, due to lack of standardization
- No PACE encounters
- No internal reliability and validity for current assessment process
- Case managers case loads are too heavy to effectively monitor clients
- No way to add providers or community resource referrals for tracking purposes
- Understaffed in terms of State oversight
- Staff turnover (lacking knowledge retention)
- MMIS does not support the EPSDT program. They do use a few reports, but a majority of them do not provide reliable data due to the programmed lag time

Notes: *No notes captured.*

CARE MANAGEMENT USE CASE	
***Business Area*:** Care Management	***Business Process:*** Manage Registry
Author(s): Beth Martin	
Facilitator: Kassie Gram	
***Actor(s)*:** Immunization Information System (CIIS), Providers, Clients, Community Partners, CDPHE, MCO	
Description: The ***Manage Registry*** is the relates to operating a registry (e.g., immunizations, cancer), receiving continuous updates, responds to inquiries, and provides access to authorized parties.	
Precondition: A registry is implemented	
***Trigger*:** Immunization event is recorded and a scheduled file cycle occurs	
Manual (M) or Automated (A)	***Steps*:**
	Operating a Registry:
1. M	1. On a weekly basis, Department staff **run** a data warehouse query to identify all currently eligible children, all providers, and all immunization claims paid during the prior week.
2. M	2. Department staff **post** data files from query results to CIIS via CDPHE's secure FTP site.
3. M	3. CIIS staff **obtain** files from secure FTP site.
4. M	4. CIIS staff **load** files into registry, cleaning data for duplicates and/or other errors.
	Response to Inquiry:
1. A	1. Start: CIIS **accepts** and **processes** MCO request files (including data validation, quality review and duplication processing)
2. A	2. Processing results are **provided** to the MCO for analysis.
3. M/A	3. CIIS **provides** results or outbound file that indicates if a there is a matching record between the MCO's file and CIIS; if yes, the results file provides immunization history for the client a. If multiple matches are returned, CIIS staff will select the best possible match and include any immunization history for the client.

1. **M** 2. **M** 3. **M** 4. **M** 5. **M**	**Providing Access to Authorized Parties:** **1.** Start: Request for registry access is **received** **2.** CIIS staff **reviews** and **determines** if the request is from an authorized and specified entity **3.** Only if approved requesting agency, CIIS staff **determines** if the requestor is covered under the existing approval **4.** If not previously approved, the appropriate authorizing mechanism is **established** (Letter of Agreement, Login Request Form, Delegation Agreement, Confidentiality Form, etc.) **5.** CIIS staff **reviews** and **approves** access as applicable

Outcome:

- Medicaid claims data are included in the statewide immunization registry.
- Data are available for providers to determine a child's immunization status.
- Data are available for quality initiatives (e.g. HEDIS calculations).

Shared Data/Interfaces:

- CIIS: External Administrative Database
- CDPHE secure FTP

To Be:

- Automated MMIS data warehouse data reports.

Failures:

- Manual processes, staff turnover
- Connectivity issues with CDPHE's secure FTP
- Maintaining current CDPHE FTP software on Department machines

Notes: *No notes captured.*

PROGRAM INTEGRITY MANAGEMENT USE CASE	
***Business Area*:** Program Integrity Management	***Business Process:*** Identify Candidate Case
Author(s): Casey Dills, Katie Brookler, Bonnie Kelly, Anne Martin, Jon Meredith, Tom Leahey, Nancy Downes, Jim Leonard, René Horton	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Program Integrity staff, providers, clients, Quality Health Improvement (QHI) staff, Pharmacy staff, contractors, Balanced Scorecard, Data Analysis staff, Policy staff, Budget staff, Program Performance staff, Internal Audit staff, MMIS, ESURS, COGNOS, TOAD, DSS, PDCS, CBMS, HEDIS – Health Effectiveness and Data Information Set, COLD	

Description:

The ***Identify Candidate Case*** business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or clients) and establishes patterns or parameters of acceptable/unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits.

Candidate cases may be identified by:

- Provider utilization review
- Provider compliance review (general claims review)
- Contractor utilization review (includes MCOs)
- Contractor compliance review
- Client utilization review (general claims review)
- Investigation of potential fraud review
- Drug utilization review
- Quality review
- Performance review
- Erroneous payment
- Contract review
- Audit Review
- Other
- Licensure expiration (facility, CLIA, professional licenses)
- Targeted Claims review (Imaging, number of services, geographic variation)
- Performance measures

Each type of case is driven by different State criteria and rules, different relationships, and different data.

Precondition: • Claims have been processed • Contracts in place • Providers are enrolled • Clients are enrolled	
***Trigger*:** • Claims are paid • Scheduled monitoring process and report review • CMS Fraud Alerts • Other State PI successful data algorithms • OIG work plan ideas • Audits	
Manual (M) or Automated (A)	***Steps*:**
	ESURS Process – Program Integrity and Policy staff identify client or provider outliers:
1. M **2. M** **3. A** **4. M** **5. M** **6. M**	1. Start: **Build** ESURS query 2. **Run** ESURS query 3. **Obtain** list of outliers 4. **Build** provider/client profile 5. **Pull** MMIS claims data related to outliers 6. End: **Analyze** claims data
	Provider Referral Process:
1. M **2. M** **3. M** **4. M**	1. Start: **Receive** referrals from any source (internal/external) 2. **Conduct** and **document** preliminary investigation on every referral 3. **Determine** if full investigation is warranted 4. End: If full investigation is warranted, **forward** referral to CIU (Program Integrity Reviewer Core) to open a case
	Utilization, Quality, Fraud Waste and Abuse Detection via Data Analysis Process (by State or Contractor):
1. M **2. M** **3. M** **4. M**	1. Start: **Identify** all cases within a defined target group 2. **Build** COGNOS or TOAD query 3. **Analyze** claims for overpayments, or under/over utilization 4. End: **Determine** if case should be opened or other action is necessary

1. **M/A** 2. **M** 3. **M**	**Data Matching Process:** 1. Start: **Match** active provider list against licensure expiration, federal exclusionary databases, and background check (review for provider death and program related felony offenses) 2. **Review** claims payment history for any claims paid for dates of service on or after license expiration or exclusion effective date 3. End: **Determine** if action is required
1. **A** 2. **M** 3. **M** 4. **M**	**Explanation of Medical Benefits (EOMB):** 1. Start: **Send** EOMB to clients 2. Clients **return** EOMB to Department 3. **Review** and **file** EOMB reply 4. End: **Determine** if action is required
1. **M** 2. **M**	**Client Overutilization Program (COUP):** 1. Start: **Receive** referral, or **pull** data on identified instances of overutilization 2. End: **Identify** overutilizers

***Outcome*:**

ESURS Process/Provider Referral Process

- Cases are opened if necessary
- Recover overpayments
- Provider education
- Fraud or False Claims are referred to law enforcement

Utilization, Quality, Fraud Waste and Abuse:

- Recommend potential system changes to prevent future overpayments
- Provider education
- Recover overpayments
- Fraud or False Claims are referred to law enforcement

Data Matching Process:

- Dead/Excluded/Non-valid licensed providers are terminated from participation
- Recover overpayments
- Report to HHS OIG

EOMB:

- Initiate referral process

COUP:

- Client is locked into a single physician and pharmacy
- Or, referral to county for client fraud investigation

Shared Data/Interfaces:

- MMIS
- ESURS
- DSS (COGNOS/TOAD)
- CBMS
- PDCS
- COLD
- CMS
- OSCAR
- DORA Licensure
- ASPEN (OASIS)
- LEIE (Medicare Exclusionary Database)
- EPLS
- MED (Medicare Exclusionary Database)
- DEA
- McSIS (Compilation database of state exclusions)
- DOLE
- Web Portal
- BUS

To Be:

- Data Mining capability (easily accessible and understandable)
- User friendly GUI (graphical user interface) and display of data
- Pre-payment review
- Update all COLD reports
- All COLD reports are produced out of DSS (instead of production environment)
- Provider check against national criminal felony history; and data contained in MMIS
- Provider affiliate list in MMIS
- Provider disclosures in MMIS
- Any information held in MMIS shall be forwarded to DSS
- Identify Providers not using Substance Abuse database (PDMP)
- Automation of Program Integrity data matching feeds and checks
- Direct interface for state-to-state databases
- Direct interface for state-to-federal databases

- Real-time notification of services, care or goods received (e-prescribing)
- Customizable provider specific alerts (automated – about their clients, about their licenses, or their specialty)
- Flexible/Nimble/Configurable/Modular system
- Integrate new BUS with MMIS, including two-way communication with CBMS

Failures:

- Manual heavy process
- Human error
- System reliability
- Lack of real-time data
- Lack of interfaces with State/Federal databases
- File size
- Process is retroactive instead of proactive (heavily pay and chase)
- CSRs take too long and are too expensive

Notes: *No notes captured.*

PROGRAM INTEGRITY MANAGEMENT USE CASE	
***Business Area*:** Program Integrity Management	***Business Process:*** Manage Case
Author(s): Shane Mofford, Marceil Case, Bonnie Kelly, John Aldag, Anna Davis, Nancy Downes, Doug van Heé	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Department staff, Program Integrity staff, OAC, Accounting staff, Attorney General's Office, Fiscal Agent, Medicaid Fraud Control Unit (MFCU) staff, State Controller, ESURS, MMIS, DSS, SAS, COFRS, OIT, COLD	

Description:

The Program Integrity, ***Manage Case*** business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or client from the Medicaid program; or the case may be terminated or suspended.

Individual state policy determines what evidence is needed to support different types of cases:

- Provider utilization review
- Provider compliance review
- Contractor utilization review [includes MCOs]
- Contractor compliance review
- Beneficiary utilization review
- Investigation of potential fraud review
- Drug utilization review
- Quality review
- Performance review
- Contract review
- Erroneous payment review

Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.

Precondition: Determination has been made to open a case.

***Trigger*:** Program integrity referral coordinator opens a case, or refers the case to another investigative unit.

Manual (M) or Automated (A)	*Steps*:
1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M** **10. M** **11. M** **12. M**	**Fee-for-Service Process:** 1. Start: Program Integrity **determines** if a data review or a records review will be performed 2. **Determine** appropriate data query 3. **Run** data query 4. **Obtain** medical records, if necessary 5. **Analyze** data output and records for fraud, waste, abuse, overpayments, provider entry error, gaps in system/rules, or required policy changes a. If fraud is suspected, the case is referred to MFCU, and/or i. Withhold provider payments as needed b. If overpayments (including waste and abuse) are identified, Program Integrity staff takes steps to recover monies, and/or c. Program Integrity staff works with Program and Policy staff to conduct provider outreach as necessary 6. **Communicate** results of analysis to the provider 7. Provider **determines** a course of action: pay in full, request informal reconsideration, request payment plan or file a formal appeal a. Pay in full – process payments as received b. Complete informal reconsideration, as necessary i. Reconsideration determination is communicated to provider ii. If provider agrees, payment is provided iii. Provider can appeal reconsideration, if desired c. Implement payment plan agreement d. File formal appeal with Office of Administrative Courts (OAC) i. Court process is implemented and followed ii. Within 90 days of OAC's receipt of the appeal, a mandatory settlement conference is conducted to attempt to settle the case without going to a hearing iii. Provider may submit written settlement offer to Program Integrity iv. Program Integrity accepts or declines settlement v. If an agreement is not reached, a hearing is scheduled 8. **Determine** final sum 9. Program Integrity staff **recovers** and **tracks** funds, as necessary 10. Program Integrity staff **reports** all recovered dollars to Accounting staff 11. Accounting staff **submits** reports to CMS 12. **Close** case upon receipt of payment in full (the agreed upon sum) or based on determination made during the hearing

1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M** **8. M** **9. M**	**Medicaid Managed Care Process:** 1. MCO verbally **notifies** Contract Manager of suspected fraud abuse 2. MCO provides **written** notification of suspected fraud abuse 3. Contract Manager **submits** referral to Program Integrity 4. If action is necessary, Program Integrity staff **logs** the referral and **refers** to MFCU as appropriate 5. MCO **investigates** suspected fraud and abuse 6. MCO **submits** written report of findings within 15 days 7. Contract Manager **forwards** MCO report to Program Integrity 8. Program Integrity **forwards** report to MFCU, as necessary 9. Contract Manager **manages** communication on findings from both MCO, Program Integrity, and MFCU as necessary

Outcome:

- Monies recovered
- Providers investigated
- Provider education/training occurs
- Providers are terminated, as necessary
- Clients are protected from fraud, waste, abuse, and criminal activity
- OIG is notified of provider sanctions (termination, withholding)
- Program policy rules are updated and system updates are implemented, if required
- CMS reporting of recoveries (and return of Federal funds)

Shared Data/Interfaces:

- MMIS
- DSS
- COFRS
- ESURS
- Master TCN database
- PDCS
- SAS
- BUS
- ASPEN (Public Health & Environment database)
- DORA
- FBI
- IRS
- COLD
- Homeland Security database

- Public records research
- Accurint for Government Plus (background search)
- LEIE – Excluded Individuals and Entities
- MED – Medicare Exclusionary Database
- EPLS – Excluded Parties List System

To Be:

- Ability to flag claims that have been previously audited
- Ability to identify the status or actions being taken on audited claims
- System utilizes historical audit data/results to trigger future audits based on configurable data points
- Review claims against established information databases (i.e., NPI, excluded provider databases, licensure databases, vital statistics)
- If it becomes necessary, streamline Medicaid network provider enrollment, if they are required to be Medicaid enrolled
- Real-time access to provider validation databases (see shared data above)
- Any pre-payment validation should not disrupt the standard payment process cycle
- NPI should be utilized as the primary provider identifier (rather than state provider ID as the primary)
- Clear and concise program rules
- Ability to run a comprehensive report of the financial transactions related to recoveries and offsets

Failures:

- System does not track previously audited claims and providers for future reference (head-bound knowledge); no way to identify impact on access to care
- No real-time link to validation databases which creates time and resource issues
- No systemic pre-payment validation process to identify approved providers prior to payment
- Time gap between identification of fraud and ability to recover funds
- Cumbersome process that is time and resource consuming
- Lack of department policy or regulatory guidance for providers
- Inability to run a comprehensive report of the financial transactions related to recoveries and offsets (currently the report can only be created by reviewing individual providers to compile the data)

Notes: *No notes captured.*

BUSINESS RELATIONSHIP MANAGEMENT USE CASE	
***Business Area*:** Business Relationship Management	***Business Process:*** Establish Business Relationship
Author(s): Cindy Ward, Erica Bol	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** CDHS, DPHE, OIT, CMS, Fiscal Agent, Contractors (Providers)	
Description: The ***Establish Business Relationship*** business process encompasses activities undertaken by the Department to enter into business partner relationships with other stakeholders for the purpose of exchanging data. These relationships include Memoranda of Understanding (MOU) and/or Interagency Agreements (IA) with other agencies; Data Use Agreements; Business Associate Agreements (BAA) with providers, managed care organizations, and others; and CMS, Provider Participation Agreement (PPA), other Federal agencies, and Regional Health Information Organizations (RHIO).	
Precondition: Need for data, or need to share data with others	
***Trigger*:** The request for data or request for a business relationship, for the purpose of exchanging data	

Manual (M) or Automated (A)	***Steps*:**
	Data Use Agreement used for limited data set:
1. M	1. Start: **Receive** request for data
2. M	2. Legal (privacy officer) **reviews** request
3. M	3. **Route** request to Executive Committee
4. M	4. Executive Committee **approves** or **denies** request (EDR)
5. M	5. **Route** the agreement through the clearance process
6. M	6. **Enter** Data Use Agreement/Business Associate Agreement into the Contract Management System for tracking purposes
7. M	7. End: **Send** signed agreement to the contractor
	Business Associate Agreement, Memorandum of Understanding and Interagency Agreement:
1. M	1. Start: **Attach** Business Associate Agreement (BAA) to contract
2. M	2. **Route** contract through Clearance Process
3. M	3. Privacy Officer **reviews** BAA to ensures it is appropriate
4. M	4. **Finalize** Clearance process and approve contract and BAA
5. M	5. End: **Initiate** contract

1. **M** 2. **M** 3. **M** 4. **M**	**Confidentiality Agreements related to RFP process:** 1. Start: **Release** RFP with Confidentiality Agreement attached as necessary 2. Potential Vendors **submit** signed agreement to Procurement 3. **Release** data relevant to the RFP 4. End: **Close** RFP process, data is returned to the state

***Outcome*:**

- Signed Data Use Agreement, BAA or IA provided to the contractor
- Requested data provided to contractor

Shared Data/Interfaces:

- CMS – Contract Management System
- MMIS
- CBMS
- BUS
- DSS

To Be:

- Automate the Clearance Process

Failures:

- Delays in Clearance Process

Notes:

Levels of Data

- Protected by Federal Regulation - Business Associate Agreement (BAA) – required authorization agreement per HIPAA
- Data Use Agreement is related to the limited data set that is utilized outside of the BAA

BUSINESS RELATIONSHIP MANAGEMENT USE CASE	
***Business Area*:** Business Relationship Management	***Business Process:*** Terminate Business Relationship
Author: Cindy Ward, Erika Bol	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Contractor, Data Analytics staff, Purchasing staff, Contract Managers	
Description: The ***Terminate Business Relationship*** business process cancels the agreement between the Department and the business or trading partner for the purpose of exchanging data. These relationships include Memoranda of Understanding (MOU) and/or Interagency Agreements (IA) with other agencies; Data Use Agreements; Business Associate Agreements with providers, managed care organizations, and others; and CMS, Provider Participation Agreement (PPA) other Federal agencies, and Regional Health Information Organizations (RHIO).	
Precondition: A Data Use Agreement, Business Associate Agreement or Interagency Agreement has been executed.	
***Trigger(s)*:** • Expiration of Data Use Agreement • Early termination of a contract could stop the BAA	
Manual (M) or Automated (A) **1. M** **2. M**	***Steps*:** 1. Start: Based on documented agreement end date, **terminate** contract 2. End: **Follow** up with contractor to determine if information has been destroyed according to the agreement * Check with Rene H/Pharmacy section about stopping data feeds when a relationship/agreement is terminated
***Outcome*:** Data is either returned or destroyed	
Shared Data/Interfaces: • CMS – Contract Management System • MMIS	

• CBMS • BUS • DSS
To Be: • Require Vendors to attest to the destruction and not copying the data
Failures: • Data destruction is not verified • Staff turnover
Notes: *No notes captured.*

BUSINESS RELATIONSHIP MANAGEMENT USE CASE	
***Business Area*:** Business Relationship Management	***Business Process:*** Manage Business Relationship
Author(s): Erika Bol, Terry Davis	
Facilitator: Rhonda Brinkoeter	
***Actor(s)*:** Contractor, Data Analytics Staff, Purchasing staff, Contract Managers	
Description: The ***Manage Business Relationship*** business process maintains the agreement between the Department and the business or trading partner for the purpose of exchanging data. This includes routine changes to required information such as authorized signers, addresses, terms of agreement, and data exchange standards.	
Precondition: A Data Use Agreement, Business Associate Agreement or Interagency Agreement has been executed.	
***Trigger(s)*:** • Requested updates to authorized signers, information, terms of agreement or required data • Business Partner requires an extension	
Manual (M) or Automated (A)	***Steps*:**
1. M **2. M** **3. M** **4. M**	**Authorized Signors process** Have Contract Managers review process and provide feedback. Reference Contractor Management processes to verify. 1. Start: Contract Manager **receives** request from Contractor (e.g., change to data feed, updated data access, or request for agreement extension) 2. Privacy Officer and/or Security Officer **reviews** request and submits to Review Board as necessary 3. Request is **approved/denied** 4. End: Approved request is **submitted** to appropriate parties for fulfillment (e.g., Data Analyst staff provides new/updated data set, agreement is updated, etc.)
1. M	**Alternate Business Relationship Sequence:** 1. Start/End: Department staff **contacts** contractor (according to the schedule) to determine if information has been destroyed according to the agreement

***Outcome*:** Business Relationship is managed
Shared Data/Interfaces: • CMS – Contract Management System • MMIS • CBMS • BUS • DSS • Web Portal
To Be: • Increase staffing • Improve IT infrastructure; Improve system capability to automate processes (i.e. reset passwords, set up credentials, etc**.)** • Ability for State staff easily add or update internal user credentials • Define data exchange requirements within the contract
Failures: • Vendors do not always submit the proper paperwork to gain proper access • State makes it difficult to get access to the information that Vendors sometimes utilize regarding other people's credentials; this is hard to proactively manage • Inability to obtain the proper tools or implement process improvement ideas such as those mentioned above • Data exchange requirements are not defined until after contracting; this causes additional work to define requirements and determine security criteria • Lack of resources • MMIS and Web Portal do not interface well creating security risks; i.e. providers remain active in the portal even if they are inactive in the MMIS
Notes: *No notes captured.*

BUSINESS RELATIONSHIP MANAGEMENT USE CASE	
***Business Area*:** Business Relationship Management	***Business Process:*** Manage Business Relationship Communication
Author(s):	
Facilitator: Rhonda Brinkoeter	
***Actor*:**	
Description: **Not currently performed by the state of CO. This capability has been added to a To Be desired state.** The ***Manage Business Relationship Communication*** business process produces routine and ad hoc communications between the Department and the business or trading partners. The Department and their business partners must agree on the content of the communications. The content depends on the business relationship. The content may be standards-based. Communication must comply with Federal and State regulations and may vary by state.	

MANAGED CARE USE CASE	
***Business Area(s)*:** Member Management, Contract Management, Provider Management	***Business Processes:*** ***Member Management:*** Determine Eligibility, Enroll Member, Disenroll Member, ***Provider Management***: Enroll Provider ***Contractor Management:*** Award Health Service Contract, Manage Administrative Contract, Award Administrative Contract
Author(s): Teresa Craig, Yoseph Daniel, Sarah Henderson, Carolyn Segalini, Paula Ring, Steve Hunter, Alan S. Kislowitz, Bill Heller, Joel Dalzell, Jenny Nunemacher, Sarah Campbell, Sharon Liu, Matt Ullrich, René Horton, Richard Delaney, Greg Trollan	
Facilitator: Kassie Gram	
***Actors*:** Contracting: Contract managers, contractors/vendors, Executive staff, Procurement staff, Rates staff, Budget staff, Accounting staff, Fiscal Agent, MMIS, CBMS, actuary Provider Enrollment: MCO/ASO, Fiscal Agent, Contract Managers, Rates staff, Fiscal Agent Operations staff, Web Portal, MMIS, Pharmacy staff Enroll/Disenroll Client: Enrollment Broker, SDAC, Enrollment staff, Eligibility staff, CHP+ Eligibility and Enrollment vendor, CBMS, MMIS, Fiscal Agent, clients, providers, Claims Systems staff, TRAILS, HMS	
Description: <u>Medicaid:</u> *Managed Care* - When a new managed care service is established in MMIS, the managed care benefit package is defined in MMIS. Claims are not processed through MMIS based on this benefit definition, but encounters may be submitted. This service tells MMIS not to pay claims for services, in general. MCO pays for everything. State pays a capitated rate to MCO. *(This differs from FFS because benefit edits in MMIS tell you what can be paid based on the FFS benefit)* <u>CHP+:</u> *Managed Care* - State pays a capitated rate to the MCO. Provider submits claims to the MCO. MCO adjudicates claims. The claims data goes to an actuary. The Actuary calculates the capitated rate that the State will pay the MCO. *ASO* – State pays administrative capitated rate to the ASO. ASO processes claims. State reconciles the difference paid for the capitations. The Actuary collects the claims data.	

This will be discussing the following processes as they relate to your Managed Care program:

- Managed Care client eligibility, enrollment and disenrollment
- Awarding and managing Managed Care contracts
- Managed Care contractor and provider enrollment

Precondition: *Not identified*

***Trigger(s)*:**

- Contract expiration
- Contract initiation
- Yearly renewal (amendment)

Manual (M) or Automated (A)	***Steps*:**
CONTRACT MANAGEMENT	***CONTRACT MANAGEMENT***
	Contracting – Renewal/Amendment:
1. M	1. Start: **Contact** vendors
2. M	2. **Determine** changes to contract
3. M	3. **Provide** draft contract
4. M	4. **Negotiate** contract language
5. M	5. **Negotiate** and **develop** rates
6. M	6. **Agree** on contract terms
7. M	7. **Coordinate** clearance process
8. M	8. **Send** final version to contractors
9. M	9. State **receives** signed contract
10. M	10. State **signs** contract
11. M	11. **Execute** contract
12. M	12. **Send** transmittal to Fiscal Agent with updates (new rates, change of services, change of beneficiaries)
13. M	13. End: Fiscal Agent **loads** new rates, services, and beneficiaries in MMIS, if applicable
	Contract Initiation:
1. M	1. Start: **Contract** awarded or approved
2. M	2. **Contact** vendors
3. M	3. **Determine** contract terms
4. M	4. **Provide** draft contract
5. M	5. **Negotiate** contract language
6. M	

7. M **8. M,** **9. M** **10. M** **11. M** **12. M**	6. **Negotiate** and **develop** rates, if necessary 7. **Agree** on contract terms 8. **Coordinate** clearance process 9. **Send** final version to contractors 10. State **receives** signed contract 11. State **signs** contract 12. **Execute** contract
PROVIDER MANAGEMENT (ENROLLMENT)	***PROVIDER MANAGEMENT (ENROLLMENT)***
13. M **14. A** **15. M** **16. M** **17. M** **18. M**	13. Vendor **completes** MMIS provider enrollment agreement (see Provider Enrollment business process) 14. **Assign** ID 15. **Create** managed care contract form 16. **Send** managed care contract form via transmittal (includes rates and services) 17. Fiscal Agent **loads** new rates, services, and beneficiaries in MMIS 18. End: If new program: a. **Modify** CBMS to add new beneficiaries (see Eligibility and Enrollment business processes use case) b. **Establish** new service in MMIS (see Authorize Service business process use case) c. **Initiate** CSR to allow receipt of encounter data in MMIS
MEMBER MANAGEMENT (ENROLLMENT)	***MEMBER MANAGEMENT (ENROLLMENT)***
1. A **2. A** **3. A** **4. A** **5. A** **6. M** **7. A**	**Enroll Medicaid Client:** 1. Start: CBMS/TRAILS **determines** eligibility 2. CBMS **transmits** eligibility data to MMIS 3. MMIS **receives** eligibility information, and for Medicaid determines appropriate managed care participation 4. MMIS **generates** Medicaid enrollment records, if applicable 5. Enrollment **auto-assigned** based on MMIS system rules: a. Passive (client can opt out) (i.e. Medicaid MCO based on geographical location and eligibility type) b. Mandatory (i.e., BHO in MMIS based on geographical location and eligibility type) 6. Enrollment **manually-assigned**: a. State **enrolls** client (i.e., PACE) b. Medicaid enrollment broker **enrolls** (i.e. all other Medicaid managed care clients) c. Or, SDAC **selects** clients for ACC enrollment i. SDAC **sends** to Fiscal Agent

	ii. Fiscal Agent **loads** in MMIS 7. End: **Generate** enrollment report
	Enroll CHP+ Client:
1. A **2. A** **3. A** **4. A** **5. A** **6. A** **7. A**	Auto-enrollment: 1. Start: CBMS **determines** eligibility 2. CBMS **determines** enrollment based on client selection through application process 3. CBMS **generates** enrollment spans using system rules 4. CBMS **transmits** eligibility and enrollment data to MMIS 5. MMIS **processes** eligibility information 6. MMIS **processes** enrollment information 7. **Generate** enrollment reports to the MCOs and ASO
MEMBER MANAGEMENT (DISENROLLMENT)	***MEMBER MANAGEMENT (DISENROLLMENT)***
	Disenroll Medicaid Client: Manual disenrollment:
1. M **2. M**	1. **Receive** request for disenrollment a. Client **requests** disenrollment b. Client **becomes** ineligible under managed care contract (PACE) c. Vendor **requests** client disenrollment 2. **Apply** end date to existing enrollment span and a disenrollment reason code
	Auto disenrollment:
1. M/A **2. A** **3. A** **4. A** **5. A** **6. A**	1. Client **becomes** ineligible under managed care contract (eligibility change or status change) 2. If ineligible, CBMS **notifies** client 3. MMIS **reassesses** client's enrollment options based on other managed care contracts available for geographical location or eligibility type 4. If FFS eligible, **notify** client 5. MMIS **generates** disenrollment file for MCO or ASO 6. If managed care and client is mandatorily enrolled, MMIS **generates** an enrollment span a. **Generate** notice/file to enrollment broker b. Enrollment broker **generates** notice to clients
	Disenroll CHP+ Client:
1. A **2. A**	1. Start: CBMS **determines** ineligibility 2. CBMS **determines** enrollment end date

3. A **4. A** **5. A** **6. A**	3. CBMS **transmits** eligibility and disenrollment data to MMIS 4. MMIS **processes** eligibility information 5. MMIS **processes** enrollment information 6. **Generates** disenrollment reports to the MCOs and ASO

Outcome:

- Managed care contracts are executed
- Managed care providers are enrolled
- Managed care clients are enrolled
- Managed care clients are disenrolled

Shared Data/Interfaces:

- MMIS
- DSS
- CBMS
- TRAILS
- SDAC
- PDCS
- COLD
- BUS
- COFRS
- Web Portal
- Trackwise (Transmittal)
- Enrollment Broker interface
- HMS

To Be:

- Capture managed care encounters from all MCOs
- CHP+ claims data should come to State
- Remove the claims processing and adjudication from the ASO to MMIS for CHP+
- PACE is auto-enrolled or enrollment broker enrolls
- Need more efficient managed care enrollment process
- Prioritization of MCO enrollment, including auto-disenrollment from lower priority program
- Automate provider enrollments
- Standardize enrollment reporting for the MCOs
- Real-time interface with eligibility system and pharmacy system
- Accurate process for paying retroactive capitations
- Track HIBI cases to avoid paying two premiums

Failures:

- Failure to process enrollment record for CHP+ client in MMIS
- Retroactive eligibility processing causes enrollment failures – overwrite of data in MMIS
- Eligibility span changes cause a loss of history from CBMS and MMIS (interface issue)
- Insufficient auditing tracking of enrollment and eligibility data
- CBMS often creates enrollment spans with end date before begin date
- Failure to terminate clients in CBMS upon exceeding program age limitations
- Overlapping spans or overlapping capitations
- Retroactive disenrollments don't get reported to the MCO in all instances
- Human error
- Time consuming
- Failure to process eligibility and enrollment records for Medicaid clients in MMIS
- When an eligibility span ends in CBMS, MMIS does not always end the enrollment or eligibility span
- For retro eligible clients, capitations aren't always paid automatically
- No way to track HIBI cases, to prevent Medicaid paying 2 premiums: 1 HIBI payment and 1 MCO capitation payment

Notes: *No notes captured.*

MANAGED CARE USE CASE	
***Business Area(s)*:** Operations Management, Program Management, Program Integrity Management,	***Business Processes:*** ***Operations Management:*** Payment and Reporting, Capitation and Premium Payment, Payment Information Management, Member Payment Management ***Program Management***: Benefit Administration, Accounting
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***Actor(s)*:** MCO, State staff, Fiscal agent, CMS, ASO, Actuary, other Health Plans, BHOs, FQHC, other state agencies, institutes, EQRO, MMIS, DSS, COFRS, Web Portal, PDCS, DRAMS, COLD, CBMS, CHP+ staff	

Description:

We will be discussing the following processes as they relate to your Managed Care program:

- Rates and Fees – Rates Setting, Develop and Maintain Benefit Package, Budget, Accounting
- Claims and Encounter Processing – Payment and reporting, Capitation and Premium payment, Cost recovery
- Utilization Review and Fraud Detection – Program analysis and reporting
- Other related processes

<u>Medicaid:</u>
Managed Care - When a new managed care service is established in MMIS, the managed care benefit package is defined in MMIS. Claims are not processed through MMIS based on this benefit definition, but encounters may be submitted. This service tells MMIS not to pay claims for services, in general. MCO pays for everything. State pays a capitated rate to MCO. *(This differs from FFS because benefit edits in MMIS tell you what can be paid based on the FFS benefit)*

<u>CHP+:</u>
Managed Care - State pays a capitated rate to the MCO. Provider submits claims to the MCO. MCO adjudicates claims. The claims data goes to an actuary. The Actuary calculates the capitated rate that the State will pay the MCO.
ASO – State pays administrative capitated rate to the ASO. ASO processes claims. State reconciles the difference paid for the capitations. The Actuary collects the claims data.

Precondition: Claims have processed through health plans.	
***Trigger*:** Scheduled time for rate setting.	
Manual (M) or Automated (A)	***Steps*:**
	Rate Setting (CHP+):
1. M **2. M** **3. M** **4. M** **5. M**	1. Start: CHP+ Health Plans **provide** encounter/claims and enrollment data to the actuary for review 2. Actuary **develops** and **publishes** rates 3. Health Plans and Department **negotiate** contract amendment 4. **Send** final rates via Transmittal 5. End: Fiscal Agent **loads** rates into MMIS
	BHO rate setting:
1. M **2. M** **3. M** **4. M** **5. M** **6. M** **7. M**	1. Start: BHOs **provide** encounters to Department for pricing and review a. Department stores encounters in a flat file b. Department pulls historical enrollment data 2. **Price** the encounter data (using CMHC Base Unit Cost provided by Division of Behavioral Health, use Hospital Rates (same rates as FFS), institute rates (in FFS) and Fee Schedule) 3. **Work** with actuary to develop rates 4. Actuary **develops** and **publishes** rates 5. BHO **reviews** the rates and verifies they are actuarially sound 6. **Send** final rates via Transmittal 7. End: Fiscal Agent **loads** rates into MMIS
	HMO rate setting / PACE rate setting:
1. M **2. M** **3. M** **4. M** **5. M** **6. M**	1. Start: **Identify** actuarially equivalent FFS population and benefit 2. **Work** with actuary to develop rate 3. Actuary **develops** and **publishes** rates 4. HMO or PACE provider **reviews** the rates and verifies they are actuarially sound 5. **Send** final rates via Transmittal 6. End: Fiscal Agent **loads** rates into MMIS
	Develop and Maintain Benefit Package (CHP+ & Medicaid)**:**
1. M **2. M** **3. M** **4. M**	1. Start: State **develops** minimum benefit plan design 2. **Define** minimum benefit plan in contracts with Health Plans and MCOs 3. **Make** changes, as needed, based on legislation and policy 4. **Load** service coverages in MMIS via transmittal

5. M	5. End: **Adjust** system configuration, as necessary
	Accounting: CHP+:
1. A	1. Start: MMIS **processes** capitation and assigns invalid GBL code
2. A	2. COFRS **receives** payment voucher
3. A	3. COFRS **rejects** all records with invalid GBL code
4. A	4. Accounting **receives** report listing breakout of capitations
5. M	5. Accounting **calculates** valid GBL assignment
6. M	6. Accounting **manually enters** valid codes into COFRS
7. A	7. End: COFRS **processes** correct payment voucher
	CHP+ State Managed Care Network Reconciliation (SMCN):
1. M	1. Start: Rates staff **develop** rates for SMCN network (based on FFS)
2. M	2. **Pay** capitation rate and administrative fee each month
3. M	3. SMCN **sends** claims extract files to State and actuary
4. M	4. State **pulls** enrollment data from various sources
5. M	5. Rates staff **performs** reconciliation of capitation to claims for a particular month
6. M	a. One month at a time, six month lag
	6. End: **Track** running total of difference, and **pay** monthly, per contract
	MCO Capitation Reconciliation of AR/AP (applies to CHP+, except claims piece):
1. M	1. Start: **True up** capitation to record of enrollment or eligibility
2. M	2. **Validate** that correct rate that was paid
3. M	3. **Ensure** there were no FFS claims paid on behalf of an enrollee, that should have been covered by MCO
4. M	a. Annual Medicaid/monthly CHP+
	4. End: **Pay** or **receive** payment
	Reconciliation Rate Setting Data to Cash Paid Out in COFRS (AP):
1. M	1. Start: **Reconcile** capitation rate to COFRS (data does not exist in MMIS)
2. M	2. End: **Perform** manual accounting adjustments
	Capitation Payment:
1. A	1. Start: MMIS **generates** capitation records, in a to-be paid status, on the first Saturday of the month
2. A	2. MMIS **pulls** the capitation records into the financial cycle on the following Friday
3. A	3. MMIS **generates** the payment voucher to COFRS (same day) and sets claims status to “paid”
4. A	
5. A	
6. A	

	4. **Generate** provider claims report, X12 transaction report, and flat file make available through the Web Portal 5. COFRS **processes** payment (EFT), and **returns** a file to MMIS with warrant number 6. End: MMIS **loads** warrant data to the claims table
1. M **2. A** **3. M** **4. M** **5. M**	**CHP+ at Work Premium Payment** 1. Start: State staff **runs** query process in an Access database 2. Access database **generates** receiving reports and invoices for all eligible clients 3. State staff **validates** receiving reports and invoices 4. State staff **submit** receiving reports and invoices to Accounting 5. End: Accounting **processes** receiving reports and invoices, and **generates** warrants through COFRS
3. A **4. M** **5. M** **6. M**	**Wrap-around payments** - made outside of MMIS (FQHC encounters, deliveries) 1. Start: MCO **submits** data (based on encounter data, but in separate file) 2. State **audits** for eligibility and enrollment 3. **Calculate** payment 4. End: **Generate** financial transaction

Outcome: Rates are set, payments are made, and financial transactions are posted.

Shared Data/Interfaces:

- MMIS
- DSS
- COFRS
- Web Portal
- PDCS
- Flat files
- DRAMS
- COLD
- CHP+ At Work database
- CBMS
- Fiscal Agent

To Be:

- Benefit package identified for Managed Care in Fee For Service is defined in the DSS
- More flexible/granular configuration of benefit plans

- Ability to adjust rates post payment
- Pay one Managed Care provider per month (no duplicates)
- Hierarchy for MCOs based on client enrollment
- More flexible/granular configuration of rate payment based on other client demographic information
- Automatically identifying institutional clients
- Ability to reimburse MCO based on encounters
- Flexibility to add additional fields for encounter data in MMIS
- Have separate logic for pricing encounters vs. FFS claims
- Ability to include CHP+ capitations in mass adjustment processes
- Ability to mass adjustment encounters/claims
- Ability to have edits unique to specific encounters
- Claims and encounters stored and identified differently in the DSS
- Ability for CHP+ income rating code data to be displayed and queried upon (MMIS/DSS)
- Ability to develop combinations of fixed and/or variable rates, including different rate add-ons, for a client, and include in one final payment

Failures:

- CHP+ capitations: MMIS assigns invalid GBL code
- Manual process to identify the FFS equivalent benefit package
- Benefit that cannot be operationalized in MMIS
- Reconciliation happens outside of MMIS (not tracked in MMIS)
- MMIS cannot pay different rates based on institutional status
- Do not have necessary fields for all encounter data in MMIS
- Inability to make mass adjustments to CHP+ claims

Notes:

CHP+ = Claims extract data
From MCO = Encounter claims data

Claims/Encounter Processing

- Receive encounter data (weekly) from MCO
- Receive BHO encounter in MMIS (monthly)
- Receive BHO encounter in flat file (quarterly, for rate setting)
- Actuary receives SMCN/HMO encounter data (monthly)
- State receives report of claims paid in subrogation annually (transactions outside accounting system)

Utilization Review – covered in balanced scorecard process

- CHP+ utilization review comes from Actuary
- External quality review (outside company – EQRO)
- MCO submits to EQRO, EQRO compiles and provides summary data (BHO quarterly/annual reports from contractors)
- Monthly, quarterly, annual reports from BHO and PACE contractors

BHO Rate Setting

The Department essentially acts as the institute bill payer on the BHO's behalf. The BHOs are still responsible for negotiating rates with the institutes and are financially liable for the institute cost. The institutional fee is taken out of the total expenditure paid to the BHO each month.

Appendix E – Comprehensive MITA Roadmap

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
Member Management	Eligibility Division	Determine Eligibility	Determine Client Eligibility		As Is	To Be			• Ability to support bi-directional interfaces (where appropriate) • Reduce lag between determination and posting data to MMIS • Centralize access to client information (by client, provider, agency, etc.) • System flexibility (ability to easily and quickly configure based on changing business requirements) • Automate workflow management • Electronic client management (incoming data, i.e. online application, and outgoing data, i.e.
		Enroll Member	Enroll Medicaid Client	As Is	To Be				
			Enroll CHP+ Client	As Is	To Be				
		Disenroll Member	Disenroll Client		As Is	To Be			
		Inquire Member Eligibility	Inquire Client Eligibility		As Is	To Be			
		Manage Member Information	Manage Client Information	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Perform Population and Member Outreach	Perform Client Outreach	As Is	To Be				notices/text for baby) • Improve reporting capabilities
		Manage Applicant and Member Communication	Manage Applicant and Client Relations	As Is	To Be				• Audit trail and access to history (automated, online, human readable)
		Manage Member Grievance and Appeal	Manage Client Appeal	As Is	To Be				• Standardize client communication • Ability to automate client education and communication • Improve and increase client communication to target areas (multi-language and multi-literate) • Standardize client assessment and care planning • Ability to create policy modeling and forecasting
Member Management	Managed Care	Determine Eligibility	Determine Eligibility		As Is	To Be			• Improve accuracy • Standardize transactions

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Enroll Member	Enroll Member (Client)		As Is	To Be			(encounter data)
		Disenroll Member	Disenroll Member (Client)		As Is/ To Be				
Provider Management	Provider Services	Enroll Provider	Enroll Provider	As Is		To Be			• Ability to support bi-directional interfaces (where appropriate) • Centralize access to client and provider data • Audit trail and access to history (automated, online, and human readable) • Automate workflow management • Electronic provider management • Improve reporting capabilities • Electronic tracking of performance measures • System flexibility (ability to
		Disenroll Provider	Disenroll Provider	As Is		To Be			
		Manage Provider Information	Manage Provider Information	As Is		To Be			
		Inquire Provider Information	Inquire Provider Information		As Is	To Be			
		Manage Provider Communication	Manage Provider Relations		As Is	To Be			
		Manager Provider Grievance and Appeal	Manage Provider Grievance and Appeal	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Perform Provider Outreach	Perform Provider Outreach	As Is	To Be				easily and quickly configure based on changing business requirements) • Automate and Improve communication (multi-language)
Provider Management	Managed Care	Enroll Provider	Enroll Provider	As Is	To Be				• Improve accuracy • Standardize transactions (encounter data)
Contractor Management	Purchasing and Contracting Services	Manage Administrative/ Health Services Contract	Manage Contract		As Is	To Be			• System flexibility (ability to easily configure based on changing business requirements) • Ability to support standard bi-directional interfaces (where appropriate) • Centralize and control access to real-time data (including documents and attachments) • Accept, store and link
		Award Administrative/ Health Services Contract	Award Contract	As Is/ To Be					
		Close-out Administrative/ Health Services Contract	Close-out Contract	As Is/ To Be					
		Produce Administrative/ Health Services RFP	Produce RFP	As Is/ To Be					

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
	Contract Manage-ment	Manage Contractor Information	Manage Contractor Information	As Is	To Be				electronic attachments (where appropriate) • Automate workflow management • Improve reporting capabilities (and automate as appropriate) • Audit trail (automate, online, human readable) • Electronic tracking of performance measures • Improve and automate electronic communication capabilities (internally and externally) • Automate Clearance process • Standardize the contracting process (including grievances and appeals) • Electronic financial management (including budget, forecasting and
		Inquire Contractor Information	Inquire Contractor Information	As Is	To Be				
		Perform Potential Contractor Outreach	Perform Potential Contractor Outreach		As Is/ To Be				
		Manage Contractor Communication	Manage Contractor Communica-tion	As Is	To Be				
		Support Contractor Grievance and Appeal	Support Contractor Grievance and Appeal	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
									payment capabilities) • Electronic utilization tracking and forecasting
Contractor Management	Managed Care	Award Administrative/ Health Services Contract	Award Contract	As Is/ To Be					• Improve accuracy • Standardize transactions (encounter data)
		Manage Administrative/ Health Services Contract	Manage Contract	As Is	To Be				
Operations Management	Agency Administra-tion and Operations	Authorize Referral	Prior Authorization	As Is	To Be				• System flexibility (ability to easily and quickly configure based on changing business requirements) • Ability to support standard bi-directional interfaces (where appropriate) • Centralize access to real-time client and provider data • Centralize access to benefit data for all programs • Accept, store and link
		Authorize Service	Prior Authorization	As Is	To Be				
		Authorize Treatment Plan	Define Benefit Packages	As Is	To Be				
		Apply Claim Attachment	Apply Claim Attachment	As Is	To Be				
		Apply Mass Adjustment	Apply Mass Adjustment	As Is	To Be				
		Edit, Audit, Price Claim/ Encounter	Edit, Audit, Price Claim/ Encounter		As Is	To Be			
		Prepare Remittance	Prepare Remittance		As Is	To Be			

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Advice/ Encounter Report	Advice/ Encounter Report						electronic attachments (where appropriate) • Automate workflow management • Improve reporting capabilities (and automate as appropriate) including leveraging meaningful use • Audit trail and access to history (automate, online, and human-readable) • Electronic tracking of performance measures • Electronic financial management • Electronic Provider Management • Improve and automate electronic communication capabilities • Improve coordination between case management
		Prepare COB	N/A	Colorado does not perform this business process					
		Prepare EOB	Prepare EOMB	As Is	To Be				
		Prepare HCBS Payment	Prepare HCBS Payment		As Is	To Be			
		Prepare Provider EFT/Check	Prepare Provider EFT		As Is/ To Be				
		Prepare Premium EFT/Check	Prepare Premium EFT/Check		As Is/ To Be				
		Prepare Health Insurance Premium Payment	Prepare HIBI Payment	As Is	To Be				
		Prepare Medicare Premium Payment	Medicare Buy-in Process		As Is	To Be			
		Prepare Capitation Premium Payment	Prepare Capitation Premium Payment		As Is	To Be			

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Manage Payment Information	Manage Payment Information	As Is	To Be				agency, county and department
		Inquire Payment Status	Inquire Payment Status		As Is	To Be			
		Calculate Spend-Down Amount	Calculate Spend-Down Amount	Colorado does not perform this business process					
		Prepare Member Premium Invoice	Prepare Member Premium Invoice	As Is	To Be				
		Manage Recoupment	Manage Recoupment	As Is	To Be				
		Manage Estate Recovery	Manage Estate Recovery	As Is	To Be				
		Manage TPL Recovery	Manage TPL Recovery	As Is	To Be				
		Manage Drug Rebate	Manage Drug Rebate		As Is	To Be			
		Manage Settlement	Manage Cost Settlement	As Is	To Be				
Operations Management	Managed Care	Prepare Capitation and Premium Payment	Prepare Capitation and Premium Payment		As Is	To Be			• Improve accuracy • Standardize transactions (encounter data)
		Manage Payment Information	Manage Changes & Reconcile Capitated Payment	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
			Information						
		Prepare Member Premium Invoice	Member Payment Management	As Is	To Be				
Program Management	Program/ Policy Manage-ment	Designate Approved Service/Drug Formulary	Designate Approved Service Formulary	As Is		To Be			• Improve reporting capabilities (and automate as appropriate) and support meaningful use • Increase staffing • Ability to support standard bi-directional interfaces (where appropriate) • System flexibility (ability to easily and quickly configure based on changing business requirements) • Improve and automate electronic communication capabilities (clients and providers) • Audit trail and access to history (automated, online,
			Designate Approved Drug Formulary	As Is		To Be			
		Manage Rate Setting	Manage Rate Setting	As Is		To Be			
		Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	As Is		To Be			
		Manage Federal Financial Participation for MMIS	Manage FFP	As Is	To Be				
		Formulate Budget	Manage Budget	As Is	To Be				
		Manage State Funds	Manage State Funds	As Is	To Be				
		Draw and Report FFP	Draw and Report FFP	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Manage F-MAP	Manage F-MAP	As Is	To Be				human-readable) • Centralize data access to real-time benefit data for all programs (Foster care, Medicaid, CHP+, LTC) • Automate workflow management • Electronic tracking of performance measures • Automate Clearance process • Automated forecasting and policy modeling • Electronic financial management (including budget and payment capabilities) • Electronic Provider Management • Automate reconciliation process
		Manage 1099s	Manage 1099s	As Is	To Be				
		Perform Accounting Functions	Accounting	As Is	To Be				
		Develop and Maintain Program Policy	Develop and Maintain Program Policy	As Is	To Be				
		Maintain State Plan	Maintain State Plan	As Is	To Be				
		Develop Agency Goals and Objectives	Develop Agency Goals and Objectives	As Is	To Be				
		Develop and Manage Performance Measures and Reporting	Develop and Manage Performance Measures and Reporting	As Is	To Be				
		Monitor Performance and Business Activity	Monitor Performance and Business Activity	As Is		To Be			
		Manage Program Information	Manage Program Information	As Is	To Be				
		Maintain	Maintain	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Benefits Reference Information	Benefits Reference Information						
		Generate Financial and Program Analysis Report	Generate Financial and Program Analysis Report		As Is	To Be			
Program Management	Managed Care	Manage Rate Setting	Rate Setting	As Is		To Be			• Improve accuracy • Standardize transactions (encounter data) • Improve internal knowledge management process
		Develop and Maintain Benefit Package	Develop and Maintain Benefit Package	As Is		To Be			
		Perform Accounting Functions	Accounting	As Is	To Be				
Program Integrity Management	Program Integrity	Identify Candidate Case	Identify Candidate Case	As Is	To Be				• Ability to support standard bi-directional interfaces (where appropriate) • Centralize and control access to real-time data • Automate workflow management • Electronic Provider Management

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
									• Electronic tracking of audit actions (incorporate CORATET) • Improve and automate electronic notification capabilities (internally and externally) • System flexibility (ability to easily configure based on changing business requirements) • Improve reporting capabilities (and automate as appropriate) • Audit trail and historical access (automate, online, human readable)
		Manage Case	Manage Case	As Is		To Be			
Business Relationship Management	Legal/ Purchasing and Contracting	Establish Business Relationship	Establish Business Relationship	As Is	To Be				• Automate Clearance process • Automate workflow management • Improve electronic contractor management
		Terminate Business Relationship	Terminate Business Relationship	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	
		Manage Business Relationship	Manage Business Relationship	As Is		To Be			• Improve and automate electronic communication capabilities (internally and externally) • Increase staffing
		Manage Business Relationship Communication	Manage Business Relationship Communica-tion	No Current Process	To Be				
Care Management	Client Services	Manage Medicaid Population Health	Manage Medicaid Population Health	As Is		To Be			• Ability to support standard bi-directional interfaces (where appropriate) • Automate workflow management • Centralize and control access to real-time data (including documents and attachments) • Improve electronic Care Management • Ability to create utilization models and forecasting • Improve and automate electronic communication capabilities (internally and
		Establish Case	Establish Case	As Is		To Be			
		Manage Case	Manage Case	As Is		To Be			
		Manage Registry	Manage Registry	As Is	To Be				

MITA Business Area	State Business Area	MITA Business Process	State Business Process	Level of Business Capability					Transition Goals for "To Be" Capability ➢ 3-5 Year Timeframe
				1	2	3	4	5	externally) • Improve and increase communication to target areas (multi-language and multi-literate) • Improve reporting capabilities (and automate as appropriate) • Standardize communication • System flexibility (ability to easily and quickly configure based on changing business requirements)

Appendix F – Initiatives Impacting the Colorado Medicaid Program

Federal Initiatives Considered
HITECH
ACA (meaningful use, adult and child core measures, provider new contract simplification/screening)
NCCI
HIPAA 5010 and 6020
ICD-10
MITA
CHIPRA
UPEP
NPI
ARRA (Enhanced FFP Match)
HIPAA Administrative Simplification – universal insurer coordination of benefits (COB); health plan identifier and attachment rules
MSIS – Medicaid Statistical Information System
NIEM – National Information Exchange Model (architecture model)
EPSDT Modernization
No-wrong door (Exchange)
Text4baby

State Initiatives Considered
MMIS Reprocurement
Department Goals and Objectives
CO-CHAMP HRSA – Colorado Comprehensive Health Access Modernization program
HCA-1293 – Colorado Health Care Affordability Act (HCAA)
ACC – Accountable Care Collaborative (SDAC)
Web Portal Reprocurement
Smart PA
eFADS/eSURS – Electronic Fraud & Abuse Detection System, Electronic Surveillance Utilization Review System
PERM – Payment Error Rate Measurement
All-Payer Database (Comprehensive Primary Care Initiative: CPCI)
COVIS – Colorado Vital Information System – Vital Statistics Interface Automation
Colorado Immunization Information System (CIIS)
Rehabilitation Information System for Employment (RISE)
Colorado Department of Corrections (DOC) – Encounter System

DOC-CHP (Correctional Health Partners Interface)
Health Information Exchange - CORHIO
Health Insurance Exchange
Money Follows the Person (CCT – Community Choice Transitions) - Benefits Utilization System updates and modernization of Long Term Care program
SLEDS Grant – Partnership with Department of Education to create a common client identifier (Statewide Longitudinal Data Study)
RAC – Recovery Auditing Contractor
HMS Contract to manage TPL information directly in the MMIS so that information is more accessible to support cost avoidance and recoveries, including capitation
Include information from Workers Comp (not implemented, but might be on the horizon)
Interface with Unemployment Insurance
DORA and DPHE (Licensing and registration programs)
APR-DRG (change to hospital reimbursement)
BHO system reform (once contract is rebid)
State Center for Medicaid Research
Department of Revenue (match client with picture “link”, for client eligibility)
SLEDS Grant – partnership with Dept. of Education to create a common identifier
Benefits Collaborative
Adoption of state-wide Contract Management System (CMS)
CBMS Enhancement
Duals Contract Grant to improve care for dual eligibles (inclusion in ACC)
EDB Data Match (CMS eligibility database match)
COPPR/ SSA 40 quarters – encourage potential Medicare recipients on Medicaid to enroll in Medicare
Adoption of SharePoint
Money Follows the Person (CCT – Community Choice Transitions) - Benefits Utilization System updates and modernization of Long Term Care program
DHS programs and systems migration
Eligibility improvement initiatives
PARIS – Public Assistance Reporting Information System (out of state recoveries)
CRM – Customer Relationship Management (stakeholders)
CCYIS – Colorado Corrections Youth Information System
Healthy Communities Outreach System (link to LTC BUS)
PEAK – Program Eligibility Application Kit
OIT Information Marketplace (same concept as data.gov)
Access to ASPEN
CUPID – Colorado Unique Person Identifier (Master Person Index)
Include information from State Employees Benefit Plan (Health Authority concept)
Global Payment demonstration project
Bundled Payment Approach

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