Deliverable to:

Colorado Department of Health Care Policy and Financing

MITA State Self-Assessment Report

Appendix B – Final Use Cases

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Table of Contents

1 – BUSINESS RELATIONSHIP MANAGEMENT USE CASES..... 2

2 – CONTRACTOR MANAGEMENT USE CASES 12

3 – CARE MANAGEMENT USE CASES 38

4 – ELIGIBILITY AND ENROLLMENT MANAGEMENT USE CASES 72

5 – FINANCIAL MANAGEMENT USE CASES 103

6 – MEMBER MANAGEMENT USE CASES..... 169

7 – OPERATIONS MANAGEMENT USE CASES..... 189

8 – PERFORMANCE MANAGEMENT USE CASES..... 217

9 – PLAN MANAGEMENT USE CASES 231

10 – PROVIDER MANAGEMENT USE CASES 259

11 – OUTLIER USE CASES..... 277

1 – Business Relationship Management Use Cases

CO MITA 3.0 SS-A Project

***Business Area*:** Business Relationship Management

Business Category: Standards Management

Business Process: Establish Business Relationship

Author(s): Kerri Coffey, Brad Shipley, John Barry

Facilitator: Nicole McNeal

Other Attendees (Non-Contributing): Ted Jones, HP

***Actor(s)*:** Colorado Department of Human Services, Colorado Department of Public Health and Environment, Office of Information Technology, Centers for Medicare & Medicaid Services, Fiscal Agent, Contractors (Providers), Department Staff

MITA 3.0 Business Process Description:

The **Establish Business Relationship** business process encompasses activities undertaken by the State Medicaid Agency (SMA) to enter into business partner relationships. Agreements are between state agency and its partners, including collaboration amongst intrastate agencies, the interstate and federal agencies. It contains functionality for interoperability, establishment of inter-agency service agreements, identification of the types of information exchanged, and security and privacy requirements. These include Trading Partner Agreements (TPA), Service Level Agreements (SLA), and Memoranda of Understanding (MOU) with other agencies; Electronic Data Interchange (EDI) agreements with providers, Managed Care Organizations (MCOs), and others; and Centers for Medicare & Medicaid Services (CMS), other federal agencies, and Regional Health Information Organizations (RHIO).

CO Business Process Description:

Colorado's **Establish Business Relationship** business process is generally aligned with the MITA 3.0 Framework. Colorado's agreements also include providers, Managed Care Organizations (MCOs), Centers for Medicare & Medicaid Services (CMS), Regional Health.

Precondition:

- Need for data, or need to share data with others

***Trigger(s)*:**

1. The request for data, exchanging data, or request for a business relationship

Manual (M) or Automated (A)		***Steps:***
		Data Use Agreement used for limited data set
1.	M	**START**: **Receive** request for data
2.	M	Legal (privacy officer) **reviews** request and determine whether a formal agreement is needed
3.	M/A	If needed, **route** request to Executive Committee
4.	M/A	Executive Committee **approves or denies** request (EDR)

5.	M	**Draft** agreement, if needed, and include Business Associate Agreement
6.	M/A	**Route** the agreement through the clearance process, via eClearance
7.	M	**Enter** Data Use Agreement/Business Associate Agreement into the Contract Management System for tracking purposes
8.	M	**Send** agreement to the business partner for signatures
9.	M	**Receive** signed agreement
10.	M	**Route** for clearance and Department signature(s)
11.	M	**Update** tracking mechanism
12.	M	**END: Send** signed agreement to business partner
		Business Associate Agreement
1.	M	**START:** Purchasing and Contracting Services Section **drafts** contract, MOU, purchase order, or IA and determines whether a BAA is needed
2.	M	If needed, **attach** Business Associate Agreement (BAA) to contract, purchase order, MOU, or IA
3.	M/A	**Route** contract, purchase order, MOU, or IA through Clearance Process
4.	M/A	Privacy Officer **reviews** contract, purchase order, MOU, or IA to ensure it is appropriate
5.	M/A	**Complete** Clearance process and sends contract, purchase order, MOU, or IA to business partner for signatures
6.	M	**Receive** signed agreement
7.	M	**Route** for clearance and Department signature(s)
8.	M	**Update** Contract Management System
9.	M	**Send** signed agreement to business partner
10.	M	**END: Initiate** contract

***Outcome*:**

1. Signed Data Use Agreement, BAA or IA provided to the contractor
2. Requested data provided to contractor

As Is Performance Metrics:	***To Be Performance Metrics:***
• There are no existing performance measures for this business process.	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. CMS – Contract Management System 2. MMIS 3. CBMS 4. BUS 5. DSS	***Shared Data/Interfaces, Outbound*:** N/A

To Be Future Vision:

1. Automate the Clearance Process

Failures of the Current Process:

1. 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

CO MITA 3.0 SS-A Project

Business Area: Business Relationship Management

Business Category: Standards Management

Business Process: Manage Business Relationship Communication

Author(s): Laura Kiel, Brad Shipley, John Barry, Kerri Coffey

Facilitator: Nicole McNeal

Actor(s): Business Partner, Purchasing Staff, Contract Managers

MITA 3.0 Business Process Description:

The **Manage Business Relationship Communication** business process receives requests for information, appointments, and assistance from business partners, such as inquiries related to a Service Level Agreement (SLA). This business process includes the log, research, development, approval, and delivery of routine or ad hoc messages. Information communicated by a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI).

CO Business Process Description:

Colorado's **Manage Business Relationship Communication** business process is generally aligned with the MITA 3.0 Framework. However, Colorado communicates with business partners on a case-by-case basis.

Precondition:

- Receive Inbound Transaction
- Establish Business Relationship
- Manage Business Relationship Information
- Terminate Business Relationship
- Maintain State Plan
- Manage Health Plan Information
- Manage Health Benefit Information

Trigger(s):

1. Receive request for assistance, such as a request for training or change in business partner information
2. Periodic timetable (e.g., monthly) is due for sending information, according to the specific agreement

Manual (M) or Automated (A)		***Steps:***
1.	M	**START: Receive** request for communication
2.	M	**Validate** information submitted is correct and as complete as possible
3.	M	**Validate** that the provided information is authentic
4.	M/A	**Determine** content and method of communication (e.g., email, mail,

		publication, mobile device, facsimile, telephone, web, or Electronic Data Interchange (EDI))
5.	M	**Prepare** content that is appropriate for the communication in agreed upon format
6.	M	**END: Generate** communication in agreed upon format

***Outcome*:**

1. Business partner receives appropriate assistance, communication, and/or information packages

As Is Performance Metrics:	***To Be Performance Metrics:***
• No current performance metrics around this process • Individual contracts specify response times to communications ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Establish a baseline for performance metrics • Document variations to baseline with explanations
Shared Data/Interfaces, Inbound: 1. Contract Management System 2. Transmittals – Trackwise (Xerox)	***Shared Data/Interfaces, Outbound*:** 1. Transmittals – Trackwise (Xerox)

To Be Future Vision:

1. Tracking information as needed for measuring performance and business activity monitoring
2. Establish a baseline of response times as specified in contracts

Failures of the Current Process:

1. Delivery failures due to erroneous contact information or lack of contact information
2. There is no established, documented procedure to track business partner communications
3. Establish a process to determine which communications should be subject to prioritization

Notes:

CO MITA 3.0 SS-A Project

Business Area: Business Relationship Management

Business Category: Standards Management

Business Process: Manage Business Relationship Information

Author(s): Laura Kiel, John Barry, Brad Shipley, Kerri Coffey

Facilitator: Nicole McNeal

Actor(s): Contractor, Data Analytics Staff, Purchasing Staff, Contract Managers

MITA 3.0 Business Process Description:

The **Manage Business Relationship Information** business process maintains the agreement between the State Medicaid Agency (SMA) and the other party such as the intrastate, interstate, and federal agencies. This includes routine modifications to required information such as authorized signers, addresses, terms of agreement, Key Performance Indicator (KPI), and data exchange standards.

CO Business Process Description:

Colorado's **Manage Business Relationship Information** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- A Data Use Agreement, Business Associate Agreement, Purchase Order, Memorandum of Understanding (MOU) or Interagency Agreement has been executed

Trigger(s):

1. Requested updates to authorized signers, information, key performance indicators, terms of agreement or required data
2. Business Partner requires an extension on Data Use Agreement, Business Associate Agreement, Purchase Order, MOU, or Interagency Agreement

Manual (M) or Automated (A)		***Steps:***
1.	M	**START:** Contract Manager **receives** request from Contractor (e.g., change to data feed, updated data access, or request for agreement extension)
2.	M	Privacy Officer **reviews and approves** request as necessary
3.	M	Approved request is **submitted** to appropriate parties for fulfillment (e.g., Data Analyst staff provides new/updated data set, agreement is updated, etc.)
4.	M	**Document** in writing any agreed upon changes and communicate agreed upon changes with business partner
5.	M	**END:** Approved request is **submitted** to appropriate parties for fulfillment (e.g., Data Analyst staff provides new/updated data set or agreement is updated)

Outcome:

<table>
<tr><td colspan="2">1. Business Relationship is managed</td></tr>
<tr><td>As Is Performance Metrics:
• N/A

Supporting Performance Metrics/SLA Documentation:
• N/A</td><td>To Be Performance Metrics:
• N/A</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. CMS – Contract Management System
2. MMIS
3. CBMS
4. BUS
5. DSS
6. Web Portal
7. DDD Web
8. SDAC</td><td>Shared Data/Interfaces, Outbound:
1. CMS – Contract Management System
2. MMIS
3. CBMS
4. BUS
5. DSS
6. Web Portal
7. DDD Web
8. SDAC</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. Improve IT infrastructure; Improve system capability to automate processes (i.e. reset passwords, set up credentials, etc.)
2. Ability for State staff to easily add or update internal user credentials
3. Knowing where all information is being sent outside the organization</td></tr>
<tr><td colspan="2">Failures of the Current Process:
1. Business partners do not always submit the proper paperwork to gain proper access
2. The State has a difficult process to obtain system access. Therefore, business partners sometimes utilize other people’s credentials.
3. Inability to obtain the proper tools or implement process improvement ideas such as those mentioned above
4. Data exchange requirements are not defined until after contracting; this causes additional work to define requirements and determine security criteria
5. Lack of resources
6. MMIS and Web Portal do not interface well, which creates security risks; i.e. providers remain active in the portal even if they are inactive in the MMIS
7. Do not know where data is being sent until there is a complication</td></tr>
<tr><td colspan="2">Notes:</td></tr>
</table>

CO MITA 3.0 SS-A Project

Business Area: Business Relationship Management

Business Category: Standards Management

Business Process: Terminate Business Relationship

Author(s): Brad Shipley, John Barry, Kerri Coffey

Facilitator: Nicole McNeal

Actor(s): Contractor, Data Analytics Staff, Purchasing Staff, Contract Managers

MITA 3.0 Business Process Description:

The **Terminate Business Relationship** business process cancels the agreement between the State Medicaid Agency (SMA) and the business partner such as the intrastate, interstate and federal agencies.

CO Business Process Description:

Colorado's **Terminate Business Relationship** business process is generally aligned with the MITA 3.0 Framework. For Colorado, the above description includes providers, Managed Care Organizations (MCOs), Centers for Medicare & Medicaid Services (CMS), Regional Health Information Organizations (RHIO), and other partners. Agreements include Trading Partner Agreements (TPA), Service Level Agreements (SLA), Memoranda of Understanding (MOU), Electronic Data Interchange (EDI) agreements, and other types of contracts.

Precondition:

- A Trading Partner Agreement, Service Level Agreement, Memoranda of Understanding, Electronic Data Interchange agreement, Data Use Agreement, Business Associate Agreement or Interagency Agreement has been executed

Trigger(s):

1. Expiration of contract, purchase order, BAA, IA, or Data Use Agreement
2. Early termination of a contract could stop the BAA

Manual (M) or Automated (A)		***Steps:***
1.	M	**START:** Based on documented agreement end date or early termination decision has been made, **terminate** contract
2.	M	**Notify** business partner of contract termination
3.	M	**Follow up** with business partner to determine if information has been destroyed according to the agreement
4.	M	**END: Ensure** that system access is terminated and/or all data feeds have been stopped

Outcome(s):

1. Data is provided, returned, and/or destroyed, as per the agreement

As Is Performance Metrics:	***To Be Performance Metrics:***
• Attestation of destruction of data from Data Review	• Attestation of destruction is

Board must be provided within one (1) year of termination ***Supporting Performance Metrics/SLA Documentation:*** • N/A	obtained within one (1) year of termination of agreement • Compliance rate for receipt of attestation from business partners = 100%
Shared Data/Interfaces, Inbound: 1. CMS – Contract Management System 2. MMIS 3. CBMS 4. BUS 5. DSS/Cognos 6. Web Portal 7. SDAC 8. DDD Web	***Shared Data/Interfaces, Outbound*:** 1. MMIS 2. CMS – Contract Management System 3. MMIS 4. CBMS 5. BUS 6. DSS/Cognos 7. Web Portal 8. SDAC 9. DDD Web
To Be Future Vision: 1. Require all business partners to attest to the destruction and not copying the data 2. Apply attestation requirement to all new systems, such as PBMS, BIDM 3. Document procedures for terminating business relationships	
Failures of the Current Process: 1. Data destruction attestation is not obtained from all business partners 2. Staff turnover results in lack of knowledge retention/loss of institutional knowledge 3. There is no consistent process for the termination of business relationships	
Notes:	

2 – Contractor Management Use Cases

CO MITA 3.0 SS-A Project

Business Area: Contractor Management

Business Category: Contractor Information Management

Business Process: Manage Contractor Information

Author(s): Beth Martin, Jerry Smallwood, Brad Shipley, Erika Bol, John Barry, and Kerri Coffey

Facilitator: Nicole McNeal and Nicole Wong

Actor(s): Purchase Orders, Projects and Contracts Databases (3 Access databases), Department Contract Staff, Department Staff Outside of Contract Staff (as required), Contractors

MITA 3.0 Business Process Description:
The **Manage Contractor Information** business process is responsible for managing all operational aspects of the Contractor (e.g., managed care, at-risk mental health or dental care, primary care physician, Recovery Audit Contractor (RAC)) data store. This business process receives a request for addition, deletion, or modification to Contractor information, validates the request, and applies the instruction.

NOTE: Requires billing agents, clearinghouses, or other alternate payees (as defined by the Secretary) to register with Medicaid agency.

CO Business Process Description:
Colorado's **Manage Contractor Information** business process is generally aligned with the MITA 3.0 Framework.

Precondition:
- Contract has been executed

Trigger(s):
1. Receipt of a request for modification to contractor information.

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Contract manager **becomes aware** of contractor information change or **receives** notification from contractor regarding contractor information change
2.	M	Contract Manager **obtains** the change in writing (e.g., email) and **reviews** the change
3.	M	If Department **identifies** the need for a change, then contract manager **informs** the Contractor of the needed change
4.	M	**Maintain** record of the request for change in contractor information
5.	M	If the change in contractor information requires a material change (e.g.,

		changes in contract scope, cost, schedule, processes, deliverables – refer to use case **Manage Contract (CO07)** (part of the Contractor Management business area)) then Contract Manager **informs** Procurement of the request for change
6.	M	Contract manager **approves and maintains** record of the request and approves change in contractor information
7.	M	**END:** Contract manager **sends** the approval in writing to the contractor

***Outcome*:**
1. Contractor information is modified

As Is Performance Metrics:	***To Be Performance Metrics:***
• Provide acknowledgement to contractor request for information, appointments, and assistance within one (1) business day ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Contract managers should be aware of authority to make changes to contractor information • For an immaterial change, a contract manager will make approved changes within ten business (10) days
Shared Data/Interfaces, Inbound: 1. None – use of email and electronic versions of contracts	***Shared Data/Interfaces, Outbound*:** 1. None – use of email and electronic versions of contracts

To Be Future Vision:
1. Eliminate paper
2. Utilize SharePoint for potentially tracking contractor information changes
3. Provide definitions for what is considered an immaterial change
4. Provide contract management training to include policies and roles and responsibilities for making changes to contracts, including immaterial changes

Failures of the Current Process:
1. Failure to document change or inaccessibility to the change
2. Lost information/folders

Notes:

Manage Contractor Communication – CO02

CO MITA 3.0 SS-A Project

Business Area: Contractor Management
Business Category: Contractor Support
Business Process: Manage Contractor Communication
Author(s): Beth Martin, Jerry Smallwood, Brad Shipley, Erika Bol, John Barry, and Kerri Coffey
Facilitator: Nicole McNeal and Nicole Wong
Actor(s): Contractor, Department Staff, Fiscal Agent, Legal and Contract Staff, Legislative Branch
MITA 3.0 Business Process Description: The **Manage Contractor Communication** business process receives requests for information, appointments, and assistance from contractors (e.g., managed care, at-risk mental health or dental care, primary care physician) such as inquiries related to modifications in Medicaid Program policies and procedures, introduction of new programs, modifications to existing programs, public health alerts, and contract amendments, etc. This business process includes the log, research, development, approval, and delivery of routine or ad hoc messages. The State Medicaid Agency (SMA) uses a variety of communication methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). **NOTE**: The **Manage Contractor Communication** business process handles current contractors by providing assistance and responses to individual entities, i.e., bi-directional communication. The **Perform Contractor Outreach (CO03)** (part of the Contractor Management business area) business process targets both prospective and current contractor populations for distribution of information regarding programs, policies, and other issues. Other examples of communications include: • Pay for performance communications – performance measures could affect capitation payments or other reimbursements • Incentives to improve encounter information quality and submission rates ***CO Business Process Description:*** Colorado's **Manage Contractor Communication** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Executed contract
Trigger(s):

Manage Contractor Communication – CO02

1. Request by contractor for information, appointments, or assistance from the Department
2. Requirement in contract to conduct the communication

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Department **receives** request for information, appointments, or assistance from the Contractor by various types of communication methods
2.	M	**Ensure** request is routed to contract manager
3.	M	**Research** request from contractor and determine appropriate Department staff who should provide response (in most cases, the contract manager)
4.	M	**END: Respond** to contractor request
		Alternate Sequence - **Data Request** (This applies to data requests that are outside the scope of the contract / not already covered by the contract):
1.	M	**Start:** Contract manager receives request for data from contractor and has contractor complete the data request form
2.	M	Data Review Board **receives** completed data request form
3.	M	Board **sends** recommendation to Executive committee for **approval** or **veto** of data request
4.	M	**Inform** contractor of decision on data request
5.	M	**End:** If approved, **distribute** data to contractor

Outcome:

1. Response is communicated to contractor

As Is Performance Metrics:	***To Be Performance Metrics:***
• Provide acknowledgement to contractor request for information, appointments, and assistance within one (1) business day • Acknowledgement of contractor's request for data outside of the contract within seven (7) calendar days • Notification of Department's decision for data request outside of the contract within sixty (60) calendar days • Provision of data to contractor is handled on a case-by-case basis ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Same as As-Is

Manage Contractor Communication – CO02

Shared Data/Interfaces, Inbound:	***Shared Data/Interfaces, Outbound*:**
1. Department website 2. Phone calls, emails, and formal forms submissions	1. Department website 2. Phone calls, emails, and formal written responses
To Be Future Vision: 1. Have secure methods for sharing files (e.g., sFTP and Skydrive Pro) 2. Select contractor have appropriate, role-based access to the DSS 3. Automated and flexible reporting for federal, state and contract requirements 4. Ability to link either physically or virtually to other data sources (e.g., vital stats, APCD, and CORHIO) 5. Have transparent access to calendars for appointment sharing with contractors 6. A way to communicate with contractor that allows for collaboration, workflow management, etc.	
Failures of the Current Process: 1. Security issues (PHI) 2. Reporting that happens out of production environment 3. Communication delays 4. Lack of automation 5. Human error	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Contractor Management
Business Category: Contractor Support
Business Process: Perform Contractor Outreach
Author(s): Kerri Coffey, Brad Shipley, Jerry Smallwood
Facilitator: Nicole McNeal
Actor(s): Contractors, Department Staff
MITA 3.0 Business Process Description: The **Perform Contractor Outreach** business process is responsible for sending information such as public health alerts, new programs, and/or modifications in the Medicaid Program policies and procedures. For prospective contractors (e.g., managed care, at-risk mental health or dental care, primary care physician), States Medicaid Agency (SMA) develops contractor outreach information for prospective contractors identified by analyzing Medicaid business needs. For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives. The SMA communicates contractor outreach information by a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). The SMA produces, distributes, tracks, and archives all contractor outreach communications according to state rules. ***CO Business Process Description:*** Colorado's **Perform Contractor Outreach** business process is generally aligned with the MITA 3.0 Framework. However, it did not reference specific outreach methods.
Precondition: • Executed contract for currently enrolled contractors, as appropriate • For prospective contractors, the Department identifies a need to identify providers • Review of information to be sent to providers and identifying appropriate audience
Trigger(s): 1. Change in policy 2. Change in fees/reimbursement 3. Request for report 4. Request for process improvement 5. Addressing client or provider complaints 6. Upcoming legislation (State requests contractor input into process)

7. Upcoming procurement activities (prospective contractors)
8. Statutory/policy requirement to communicate to providers (for example, monthly provider bulletin)
9. Other need to communicate information to providers

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Send** direct communication or **create** indirect communication for outreach to contractor or prospective contractors
2.	M	**END: Address** any feedback, questions, or concerns received from contractor or prospective contractor

Outcome:
1. Information is communicated to contractors or prospective contractors

As Is Performance Metrics:	***To Be Performance Metrics:***
• Acknowledge external communications within 1 business day • Monthly Provider Bulletin is released on the first of every month • There are no other documented performance measures related to this business process ***Supporting Performance Metrics/SLA Documentation:*** • External communication: HCPF SOP • Monthly Provider Bulletin	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. Email (e.g., Dept. receives notification of change in policy) 2. Phone call 3. Published rule, policy, statute, Federal Register	***Shared Data/Interfaces, Outbound***: 1. BIDS 2. Website 3. Contractor FTP sites 4. BUS 5. Web Portal 6. MMIS 7. PDCS

To Be Future Vision:
1. BUS to interface with MMIS in order to improve access and dissemination of information to providers
2. Paperless process
3. Have State owned secure FTP site (where we an assign contractor log-in information) rather than accessing contractor's FTP site
4. Automatic triggers for the type of communication distributed to providers
5. Use a greater variety of types of communication to providers (e.g. text messaging, social

media)
Failures of the Current Process: 1. Security issues (PHI)
Notes:

CO MITA 3.0 SS-A Project

Business Area: Contractor Management

Business Category: Contractor Information Management

Business Process: Inquire Contractor Information

Author(s): Kerri Coffey, Jerry Smallwood, Brad Shipley, Jane Wilson

Facilitator: Nicole McNeal

Actor(s): Department Contract Staff, Legal, Potential Vendor

MITA 3.0 Business Process Description:
The **Inquire Contractor Information** business process receives requests for contract (e.g., managed care, at-risk mental health or dental care, Primary Care Physician (PCP)) verification from authorized providers, programs or business associates, performs the inquiry, and prepares the response for the **Send Outbound Transaction**.

CO Business Process Description:
Colorado's **Inquire Contractor Information** business process is generally aligned with the MITA 3.0 Framework. This is called a CORA Request in the State of Colorado. Colorado also receives requests from vendors, Colorado legislature, or the general public.

Precondition:
- Executed contract

Trigger(s):
1. Receipt of request for contract details

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** request in writing for contract details
2.	M	**Send** request to Legal Department
3.	M	Legal Division responds to request, within 3 business days or in compliance with C.R.S. 24-72-200 et seq.
4.	M	Legal Department **conducts** research
5.	M	**END: Provide** response to requestor

Outcome:
1. Response is provided to requestor

As Is Performance Metrics:	***To Be Performance Metrics:***
• Legal Division responds to request, within 3 business days or in compliance with C.R.S. 24-72-200 et seq. • Statute requires that the Department respond in 3 business days, or exercise an extension of time to reply of an additional 10 days	• Same as As-Is

Supporting Performance Metrics/SLA Documentation: • N/A	
Shared Data/Interfaces, Inbound: 1. Email request 2. Phone request	***Shared Data/Interfaces, Outbound*:** 1. Email response 2. Phone response 3. Paper response 4. Electronic media response
To Be Future Vision: 1. Public access to the Contract Management System 2. Electronic access to all contracts by the public	
Failures of the Current Process: 1. Current process is time consuming 2. Current process is more paper intensive than necessary. Over 90% of CORA responses are electronic, either sent by email or on a CD 3. It can be difficult to understand requests 4. Requestors who are not familiar with the Colorado Open Records Act (CORA) may submit an inappropriate request	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Contractor Management

Business Category: Contract Management

Business Process: Produce Solicitation

Author(s): Kerri Coffey, Ben Drendel, Jerry Smallwood, Brad Shipley

Other Attendance (non-contributing): Sienna Apis, Erick Croy

Facilitator: Nicole Wong

Actor(s): Procurement Staff, Program Staff, Vendors

MITA 3.0 Business Process Description:
The **Produce Solicitation** business process gathers requirements, develops a solicitation (e.g., Request for Information (RFI), Request for Quotation (RFQ), or Request for Proposals (RFP)), receives approvals for the solicitation, and releases for response.

CO Business Process Description:
Colorado's **Produce Solicitation** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- Need identified for a program, initiative, service, product, or additional information from the vendor community

Trigger(s):

1. Anything requiring a new vendor. For example:
   - Contract expiration
   - New statute, regulation or rule requiring a new vendor
   - Failing vendor
   - New program, service, initiative, or product

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Department **determines** that a solicitation is needed and contacts Procurement regarding the need for a solicitation
2.	M	Procurement director **approves** the request to the program staff and assigns procurement staff to identify the scope of the solicitation
3.	M	Procurement staff **works** with Program staff to determine requirements for scope of solicitation
4.	M	Procurement staff **drafts** solicitation language
5.	M	Program staff and subject matter experts **review** draft solicitation
6.	M/A	Once program staff **approves** of draft solicitation, **initiates** Clearance process

7.	M	Procurement staff **completes** Evaluation Criteria in collaboration with program staff and **updates** the solicitation as necessary
8.	M	Procurement staff and Program staff **assemble** the Proposal Evaluation Committee
9.	M	Procurement staff **finalizes** and **posts** solicitation to BIDS
10.	M	Procurement staff **receives** questions from interested parties and **coordinates** with Program staff to answer questions and/or modify solicitation as necessary
11.	M	Procurement staff **posts** any solicitation modifications and responses to questions to BIDS
12.	M	**END:** Procurement staff **receives** vendor proposals/responses
		Alternate Sequence: Confidentiality Agreements Related to Solicitation Process:
1.	M	**START:** When confidential information might be required as part of solicitation**, release** solicitation with Confidentiality Agreement attached
2.	M	Potential bidders/vendors **submit** signed Confidentiality Agreement to Procurement
3.	M	Procurement **releases** data in accordance with the Confidentiality Agreement
4.	M	**END:** Once solicitation closes, **validated** data is returned to the state or destroyed

***Outcome*:**
1. Receipt of vendor proposals/responses
2. Failed procurement due to lack of receipt of acceptable proposals

As Is Performance Metrics:	***To Be Performance Metrics:***
• BIDS requires that RFPs must be posted for at least thirty (30) calendar days on BIDS (R-24-103-203-07) • If the solicitation is a documented quote, it must be posted for at least three (3) business days (R-24-103-204-03(e)) • IFBs need to be posted for a minimum of 14 days in accordance with R-24-203-202a-01(c). • Destruction of data must occur within one (1) year ***Supporting Performance Metrics/SLA Documentation:*** • See in-line references above	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. SharePoint 2. Email	***Shared Data/Interfaces, Outbound*:** 1. BIDS

3. Phone calls	2. Email 3. Phone calls 4. Electronic media
To Be Future Vision: 1. Fully automated and electronic clearance process 2. Ability to accept proposals via CORE	
Failures of the Current Process: 1. Clearance process is time consuming	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Contractor Management

Business Category: Contract Management

Business Process: Award Contract

Author(s): Kerri Coffey, Ben Drendel, Jerry Smallwood, Brad Shipley

Other Attendance (non-contributing): Sienna Apis, Erick Croy

Facilitator: Nicole Wong

Actor(s): Purchasing Director, Procurement Staff, Program Staff, Evaluation Team

MITA 3.0 Business Process Description:

The **Award Contract** business process utilizes requirements, advanced planning documents, requests for information, request for proposal, and sole source documents to request and receive proposals, verify proposal content against Request for Proposal (RFP) or sole source requirements, apply evaluation criteria, designate contractor/vendor, post award information, entertain protests, resolve protests, negotiate contracts, and notify parties. In some States, this business process makes a recommendation of award instead of the actual award itself.

NOTE: The State Medicaid Agency (SMA) requires billing agents, clearinghouses, or other alternate payee (as defined by the Secretary) to register.

CO Business Process Description:

Colorado's **Award Contract** business process is generally aligned with the MITA 3.0 Framework. Colorado requires billing agents, clearinghouses, or other alternate payee (as defined by the Secretary) to register as a vendor for the State. Any bidder in any organization that wants to view a solicitation on BIDS must register on BIDS, and therefore, they must be registered in BIDS to submit a proposal/response.

Precondition:

- Solicitation is posted to BIDS

Trigger(s):

1. Receive proposal/response

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** proposal(s)/response(s)
2.	M	Procurement staff **review** minimum mandatory solicitation submission requirements
3.	M	**Gather** and **meet** with evaluation team
4.	M	Evaluation Team **evaluates** proposals
5.	M	Evaluation Team **submits** recommendation to Purchasing Director for

		approval
6.	M	**If approved,** intent to award is communicated to all bidders and posted on BIDS
7.	M	**Allow** 7 business day protest period
8.	M	**Conduct** contract negotiations and finalize contract document(s)
9.	M/A	**Initiate** clearance process (Refer to BR01 use case)
10.	M	**END**: **Execute** contract
		Alternate Sequence if Award is Protested
1.	M	Purchasing Director **receives** vendor's written protest
2.	M	**Review** nature of protest
3.	M	**Prepare** response to the protest
4.	M	**Provide** response to the vendor(s)
5.	M	**END** If vendor decides not to pursue any action
6.	M	If vendor **pursues** action, vendor **takes** the response to State Purchasing Director, then Purchasing Director holds hearing with the Department and vendor
7.	M	**Provide** a written decision within thirty days of the hearing.
8.	M	Denver District Court **responds** to contractor within 10 days (copy State Purchasing and Executive Director). Response outlines due process (appeal rights).
9.	M	Contractor can **appeal** the response

Outcome:

1. Awarded and executed contract

As Is Performance Metrics:	***To Be Performance Metrics:***
• The purchasing director has 20 working days (unless otherwise extended) to respond to a protest, or else the protestor may act as if the decision had gone against them and appeal (C.R.S. 24-109-107). • If they appeal, they have 10 working days (unless they were determined to be debarred or suspended, in which case they have 20 day) to file the appeal with the ED of DPA or a designee (usually the State Purchasing Director) (C.R.S. 24-109-203). • The state must then make a decision within 30 working days (24-109-204(2)(A)). After either the initial protest decision or the appeal decision, the offeror has 10 working days to file a case in district court (C.R.S. 24-109-206).	• Same as As-Is

Supporting Performance Metrics/SLA Documentation: • C.R.S. 24-109-107 • C.R.S. 24-109-203 • C.R.S. 24-109-206	
Shared Data/Interfaces, Inbound: 1. Proposals/responses 2. Protests and appeals	***Shared Data/Interfaces, Outbound*:** 1. BIDS 2. Responses to protests and appeals 3. Intent to award notification
To Be Future Vision: 1. 100 percent eClearance until signature steps 2. Better way to identify evaluation committee members who have the time and desire to sit on committee; create electronic system that identifies potential committee members by experience. Store committee members information in database for future reference 3. Streamline/automate evaluation data collection and scoring process	
Failures of the Current Process: 1. No respondents	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Contractor Management		
Business Category: Contract Management		
Business Process: Manage Contract		
Author(s): Teresa Craig, Marceil Case, Michelle Miller, Kerri Coffey, Melanie Reece, Challon Winer		
Other Attendance (non-contributing): Daniel Butler, JC Chang		
Facilitator: Nicole Wong		
Actor(s): Contract Managers, Claims Systems (system changes) and Operations (Fiscal Agent)		
MITA 3.0 Business Process Description: The **Manage Contract** business process receives the contract award information, implements contract-monitoring procedures, updates contract if needed, and continues to monitor the terms of the contract throughout its duration. ***CO Business Process Description:*** Colorado's **Manage Contract** business process is generally aligned with the MITA 3.0 Framework.		
Precondition: • Contract manager assigned		
Trigger(s): 1. Contract execution		
Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Conduct** initial contractor meeting (review deliverables, timelines, responsibilities between State and Contractor)
2.	M	**(Optional) Conduct** kick off meeting
3.	M	**Monitor** contract deliverables, due dates, feedback on deliverables, **understand** contractor processes, **facilitate** contractor payment
4.	M/A	**Monitor** contract and **manage** Contractor performance according to contract terms. Monitoring activities may include Quality and Health Improvement (QHI) staff, validation of performance measures and annual site reviews.
5.	M	Contract Manager **distributes** results of reviews/validations as necessary
6.	M	Contract Manager **manages** contract changes: amendments, renewals (i.e., cost, schedule, scopes of work)
7.	M/A	**Execute** contract changes
8.	M	**END: Trigger Close Out Contract (COO8)** business process (part of the

		Contractor Management Business area)

Outcome:
1. Contracted services are successfully provided to covered populations
2. Contractor is compensated accurately and timely

As Is Performance Metrics:	***To Be Performance Metrics:***
• Statutory requirement to pay contractors within 45 days of invoice, unless otherwise specified in contract. (Specified in invoicing section of each contract. May be reduced from 45 days in contract negotiations.) ○ Regardless of the contract requirements, though, C.R.S. 24-30-202(24)(a) makes HCPF subject to payment of interest after 45 days if we do not make payment • Additional performance measures unique per contract. ***Supporting Performance Metrics/SLA Documentation:*** • C.R.S. 24-30-202(24)(a)	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. Depends on contract (i.e., general MMIS, and its subsystems, interfaces between State and Contractor) for example State share and Trackwise (Xerox systems) 2. SharePoint 3. Stakeholder input (meetings, emails etc.) 4. Department/Contractor meetings	***Shared Data/Interfaces, Outbound***: 1. HCPF Community Board Notices 2. HCPF Website Information 3. At a Glance 4. Provider bulletins 5. COFRS/CORE 6. Department/Contractor meetings 7. Depends on contract (i.e., general MMIS, and its subsystems, interfaces between State and Contractor) for example State share and Trackwise (Xerox systems) 8. Contract Management System

To Be Future Vision:
1. Department automates more processes and/or reports, when feasible
2. Notifications for timing (tickler file, milestones, deliverables)
3. Notification of reporting requirements, approvals

4. Document management 5. Notification of when contract term ends (start process for RFP) 6. Standardize notification system for internal use (department-wide tickler system) 7. Automate waivered contracts 8. Combined Department system searchable by office, division and section 9. Monitoring – increase ability to communicate positive performance 10. Contractor/admin payments captured in MMIS 11. Contract manager training 12. Require more automation from Contractors, as applicable 13. Contractor invoicing will be more automated in CORE when that goes online in July (invoices submitted through CORE will go directly into the financial payment section of the system)
Failures of the Current Process: 1. Staff member leaves (contract manager), lack of structured documentation for knowledge transfer (Little consistency amongst contract manager documentation for new people to pick up when someone leaves)
Notes:

CO MITA 3.0 SS-A Project

Business Area: Contractor Management

Business Category: Contract Management

Business Process: Close Out Contract

Author(s): Teresa Craig, Marceil Case, Michelle Miller, Kerri Coffey, Melanie Reece, Challon Winer

Facilitator: Nicole Wong

Actor(s): Contract Managers, Claims Systems (system changes) and Operations (Fiscal Agent), Contractors, Department Legal (pulled in by Contract Manager), Department Purchasing

MITA 3.0 Business Process Description:
The **Close Out Contract** business process begins with an expired contract or an order to terminate a contract. The business process ensures the obligations of the current contract are complete and the turnover to the new contractor proceeds according to contractual obligations.

CO Business Process Description:
Colorado's **Close Out Contract** business process is generally aligned with the MITA 3.0 Framework. Colorado subject matter experts specified that that the business process ensures the obligations of the current contract are complete and the turnover to the new contractor proceeds according to contractual obligations as necessary.

Precondition:
- Contract term ends
- Contract breach / business failure
- Loss of funding

Trigger(s):
1. Receive instruction to terminate contract
2. Notification of loss of funding or business failure
3. Contract obligations have been fulfilled and/or term ends

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: As required by contract, Contractor to **provide** transition plan
2.	M	Contract manager **verifies** contractor has met all requirements
3.	M	Contract manager **verifies** all obligated funds have been appropriately disbursed
4.	M/A	**END:** Contract is **closed**
		Alternate Sequence Due to Breach in Contract:

1.	M	**Contact** Legal and Purchasing
2.	M	**Optional: Contact** Policy, Communications, and Operations Office
3.	M	Department **pays** for any work completed prior to breach, once invoice has been received for the work
4.	M	**END:** Contract is **closed**

Outcome:
1. Contract is closed out

As Is Performance Metrics:	***To Be Performance Metrics:***
• Follow terms of contract • Health and safety violations trigger timeframes for closing contract, per terms of contract • State requirements for keeping contract documentation (6 years after date of contract expiration) (State Records Management Manual promulgated by the state archives under title 24, article 38 of the CRS – Schedule 7, section A.3) • Verify Contractor has met requirements of a transition plan prior to receiving any disbursement of funds. ***Supporting Performance Metrics/SLA Documentation:*** • State Records Management Manual promulgated by the state archives under title 24, article 38 of the CRS – Schedule 7, section A.3	• Follow terms of contract
Shared Data/Interfaces, Inbound: 1. Email, phone call or meeting	***Shared Data/Interfaces, Outbound***: 1. Email or phone call

To Be Future Vision:
1. Standardized process for contract close-out activities
2. System/electronic tracking of activity status (e.g. to be completed, completed & date, end of retention period)
3. Training for close-out process
4. Add terminated contracts to Contract Management System
5. Process for destruction after required retention period
6. Use Contract Management System for retention and destruction notification
7. CORE may be replacing the Contract Management System when it comes online, and so there may be no need to add terminated contracts (or new contracts) to CMS anymore or to sue that system for retention and destruction notification

Failures of the Current Process:
1. Lack of standardized process

Notes:
1. Uncooperative transition

2. Unexpected contract termination leads to no vendor ready to assume responsibility
3. No contingency plan
4. Administrative complexity of procurement/contract/approval process to have successor ready to assume responsibilities from outgoing contractor

Manage Contractor Grievance and Appeal – CO09

CO MITA 3.0 SS-A Project

Business Area: Contractor Management
Business Category: Contractor Support
Business Process: Manage Contractor Grievance and Appeal
Author(s): Kevin Dunlevy-Wilson, Teresa Craig, Melanie Reece, Hela Sahli, Kirstin Michel, Meredith Henry, Sean Bryan, Challon Winer
Other Attendance (non-contributing): JC Chang, Daniel Butler
Facilitator: Christine Rohrer
Actor(s): Prospective or Non-Awarded Contractors, Contractors, Department Staff, Department Procurement, Attorney General (AG)
MITA 3.0 Business Process Description: The **Manage Contractor Grievance and Appeal** business process handles contractor (e.g., managed care, at-risk mental health or dental care, primary care physician) appeals* of adverse decisions or communications of a grievance. The **Manage Contractor Communication (CO02)** business process (part of the Contractor Management business area) initiates a grievance or appeal. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal; it triages to appropriate reviewers; it researches it; it may request additional information; it schedules and conducts a hearing in accordance with legal requirements; and it makes a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the contractor's information. Agency formally notifies contractor of the decision. This business process supports the **Manage Performance Measures (PL05)** business process (part of the Plan Management business area) by providing information about the types of grievances and appeals it handles; grievance and appeals issues; parties that file or are the target of the grievances and appeals; and the dispositions. This information used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. Based on the appeal business process, if a contractor wins an appeal that impacts or clarifies a Medicaid State Plan, health plan, or health benefit this process sends that information to **Maintain State Plan (PL03), Manage Health Plan Information (PL04)** or **Manage Health Benefit Information (PL06)** business processes (part of the Plan Management business area) to modify the relevant policy or procedure. Disposition could result in legislative change requirements that will be communicated to lawmakers. **NOTE**: States may define grievance and appeal differently, perhaps because of state laws. *This business process supports grievances and appeals for both prospective and current

contractors. A non-enrolled contractor can file a grievance or appeal, for example, when agency does not award a contract to contractor. Protests received from prospective contractors are addressed in the Award Contract business process

CO Business Process Description:
Colorado's **Manage Contractor Grievance and Appeal** business process is generally aligned with the MITA 3.0 Framework.

Precondition:
- Contract awarded

***Trigger(s)*:**
1. Prospective or non-awarded contractor files a protest
2. Contractor appeals a policy decision or audit finding

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Prospective or non-awarded contractor **files** written protest within 7 days of date of award
2.	M	State **responds** to protest within 10 days
3.	M	If prospective or non-awarded contractor files an appeal with State purchasing director or Denver District Court, appropriate party **makes** decision about protest
4.	M	**END:** State **sends** response to prospective or non-awarded contractor
		Policy and Rule Changes
1.	M	**START: Communicate** new or changed policy to contractor
2.	M	Contractor **responds** with concern related to new or changed policy
3.	M	Contract manager provides response to contractor concern.
4.	M	If unresolved, follow escalation procedure (See Notes section, below)
5.	M	Contractor pursues all avenues for resolution
6.	M	Appropriate party **makes** decision
7.	M	**END:** State **sends** response to contractor
		Audit Finding:
1.	M	**START: Communicate** audit finding to contractor
2.	M	Contractor **appeals** or **asks** for reconsideration
3.	M	Department **considers** new evidence
4.	M	**END:** Department **makes** decision and communicates to contractor

***Outcome*:**
1. Department **responds** to contractor concern or prospective or non-awarded contractor protest, appeal, or grievance

As Is Performance Metrics:	***To Be Performance Metrics:***

Manage Contractor Grievance and Appeal – CO09

• Prospective or non-awarded contractor **files** written protest within 7 business days of date of award • State responds to protest within 10 business days • Other awards have no formal time period in statute for protest. ***Supporting Performance Metrics/SLA Documentation:*** • C.R.S. 24-109-102	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. PDCS 2. BIDS 3. Email, mail	***Shared Data/Interfaces, Outbound*:** 1. BIDS (prospective contractor) 2. Email, mail
To Be Future Vision: 1. Standardized/formal process 2. Shared internal database to track appeals and audit findings 3. CORE will replace BIDS	
Failures of the Current Process: 1. No standardized or formal process in place 2. No database	
Notes: The first level of escalation after internal management would be to the purchasing director to determine if there is a need for breach or other legal remedies. Section 20.E of the template contract has a disputes section that requires that disputes go up through appropriate management to be resolved. While any decision could be cause for court action from the contractor, the appeal to the state procurement director is only formally available for protesting award decisions. C.R.S. 24-109-102 sets the 7 working day protest period for RFP and IFB awards. Other awards have no formal time period in statute for protest.	

3 – Care Management Use Cases

Establish Case – CM01

CO MITA 3.0 SS-A Project

Business Area: Care Management
Business Category: Case Management
Business Process: Establish Case
Author(s): Kevin Dunlevy-Wilson, Teresa Craig, Melanie Reece, Hela Sahli, Kirstin Michel, Meredith Henry, Sean Bryan, Gina Robinson
Other Attendance (non-participating): JC Chang, Daniel Butler
Facilitator: Christine Rohrer
Actor(s): Client, Family Members, Providers (including Case Management Agencies, Case Managers, Nursing Facilities, Home Health Agencies, Physicians, and HCBS Providers), Department staff, Other State Agencies (e.g., DOE, DHS), Community Organizations, Advocacy Agencies, Fiscal Agent, CMS, PPL

MITA 3.0 Business Process Description:
The Care Management, **Establish Case** business process uses criteria and rules to:
• Identify target members for specific programs
• Assign a care manager
• Assess the member's needs
• Select a program
• Establish a treatment plan
• Identify and confirm provider
• Prepare information for communication
This business process may establish a case for one individual, a family or a target population such as:
• Medicaid Waiver program case management
  ○ Home and Community-Based Services (HCBS)
  ○ Other
• Disease management
• Catastrophic cases
• Early Periodic Screening, Diagnostic, and Treatment (EPSDT)
• Vaccines for children and adults
• Population management
This business process may initiate a case from claim processing indicators such as:
• Several claims for an individual member over a time interval
• New claims close to discharge date
• Claims containing one of the with the following:
  ○ Place of Service - Certain Places of Service
  ○ Discharge Date

- Admit Date
- PWK - Attachments containing lab results, treatment plans, etc.
- NTE - Notes containing discharge plans, goals, treatment plan
- EPSDT Referral Claim
- Claims containing certain types of the following information:
- Principle Diagnosis
- Admitting Diagnosis
- Patient Reason for Visit
- Other Diagnosis Information
- Principle Procedure
- Other Procedure

CO Business Process Description:

- Colorado's **Establish Case** business process is generally aligned with the MITA 3.0 Framework. Colorado's process also specifies notification to persons who are age 20 and under or pregnant women of all ages who are required to be notified of available services and access to those services within 60 days of eligibility and annually thereafter. Of services and access to those services within 60 days of eligibility and annually thereafter. EPSDT includes well care, oral health, lead testing and developmental screening. In Colorado a case may be initiated from claims such as all diagnosis codes listed on well care and sick care visits, not just at admitting.

Trigger(s):

1. Referral from providers, case management agencies, counties, contractor, relatives, community-based organizations, parents, etc. (happens before or after eligibility determination)

Manual (M) or Automated (A)		***Steps:***
		All (except EPSDT)
1.	M	**START**: Case management agencies, contractors, or DHS **conduct** screening and referral
2.	M	**Schedule** the assessment, if determined appropriate in Step 1
3.	M	Case Manager is **assigned** to applicant
4.	M	Case Management agency **performs** assessment to determine if applicant might meet functional eligibility and targeting criteria
5.	M	Case Manager is **assigned** to applicant
6.	M	**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)
7.	M	**END:** Based on client's choice and appropriateness, Case Manager **selects**

		appropriate program
		Nursing Facility (Institution)
1.	M	**START: Complete** Steps 1-5 and 7, from "All" steps
2.		**Submit** Prior Authorization request (form 5615)
3.	M	**Administration** of PASRR (Pre Admission Screening and Resident Review) Level I (and Level II if required)
4.	M	**Submit** for review and approval to the Long Term Care Utilization Review Contractor
5.	M	**END**: If approved, client **enters** or **remains** in nursing facility under Medicaid
		HCBS
1.	M	**START: Complete** Steps 1-5 and 7, from "All" steps
2.		Case Manager **develops** service plan, including non-Medicaid supports, with client and family
3.	M	Client is **given** choice of HCBS supports
4.	M	Case Manager **provides** client with provider choices that meet service needs
5.	M	Client **selects** providers
6.	M	Case Manager **arranges for** providers to begin providing care
7.	M	**END**: Case Manager **completes** Prior Authorization process (note: there is variation in who approves)
		PACE
1.	M	**START:** Complete Steps 1-5 and 7, from "All" steps
2.		Case Manager **develops** service plan with client and family
3.	M	If client chooses PACE program, Case Manager **refers** client to local PACE program
4.	M	**END:** PACE program **completes** enrollment
		LT Home Health
1.	M	**START: Complete** steps 1-5 and 7, from "All" steps
2.		Home health agency or SEP **receives** referral
3.	M	Home health agency **develops** Plan of Care
4.	M	**Send** Plan of Care to case management agency for review
5.	M	**Respond** to questions about the medical necessity of services presented in the care plan, as necessary
6.	M	**END:** Case management agency **completes** PAR and UM vendor **approves** Prior Authorization
		CDASS (Subset of HCBS)
1.	M	**START**: Determine client is appropriate for self-determination
2.	M	Client **identifies** attendants
3.	M	Financial Management Services contractor trains and hires attendants

4.	M	Case Manager **completes** task worksheet and **determines** allocation
5.	M	Case Manager **completes** consumer directed service plan
6.	M	**END: Approve** service plan
		EPSDT
1.	M	**START**: Client **qualifies** for EPSDT (program is automatically available to financially eligible Medicaid clients who are 20 years of age or under, or if pregnant)
2.	M	Department **notifies** clients of available services, how to access them, and notifies pregnant women of the availability of case management, referrals and resources
3.	M	Physician **performs** standard wellness check, or additional services as necessary (EPSDT screen) according to AAP Bright Futures periodicity schedule (Oral health screenings twice a year, lead testing and developmental screening of 3 screens by age 3)
4.	M	**END**: Department **assigns** EPSDT Family Health Contractor as specified by contracts and sends the contractor information on the assignment

Outcome:

1. Client is successfully enrolled in the program, and receives appropriate care, as specified by the AAP Bright Futures periodicity schedule and any other scheduled defined by the Department
2. Client is denied and no case is established
3. EPSDT outcomes: 80% of the children eligible for Medicaid have well child check and two oral health care visits within each Federal fiscal year, as well as appropriate lead testing at 12 and 24 months or between the ages of 36 and 72 months if not previously tested, and behavioral health screening of three screens by the age of 3 utilizing code 96110. Should also report on use of code 99420, depression screening for all pregnant women and children and youth ages 11 through 20.

As Is Performance Metrics:	***To Be Performance Metrics:***
• QIS measures ***Supporting Performance Metrics/SLA Documentation:*** • HCBS Waiver Agreement with CMS • HCPF Volume 8 Rules and Regulations	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS 3. BUS 4. SalesForce (feeds into CBMS) 5. CBMS 6. CCMS	***Shared Data/Interfaces, Outbound***: 1. MMIS 2. DSS 3. BUS 4. SalesForce (feeds into CBMS)

7. PPL 8. ASPEN 9. COLD 10. New EPSDT data system 11. TRAILS 12. MDS	5. CBMS 6. CCMS 7. CMS 8. PPL 9. ASPEN 10. COLD 11. New EPSDT data system 12. TRAILS
To Be Future Vision: 1. Disease management program 2. Catastrophic cases program 3. Population management program 4. Interface between BUS and SAMS (older adult)/CCMS (DD), or common LTC Case Management platform (regardless of funding stream) 5. Interface between LTC Case Management platform and MMIS/DSS 6. Interface with BUS and CBMS and/or Health Information Exchange 7. Resource support for BUS or new Case Management system 8. Workflow for Case Management process 9. Improved ad hoc reporting capabilities 10. Automated prompts to Care Managers (ticklers) 11. Less subjective assessment and care planning process, supported by a robust Care Management System – leading to standardization of assessment and care planning processes 12. PACE encounters 13. System integrated, internal performance measures 14. Satisfaction surveys for clients, with results available in DSS 15. Provide access to a new database for EPSDT (the database is built and being used, but there needs to be an electronic interface between MMIS and that system for those items outlined above. 16. Electronic interfaces for PAR and UM vendors	
Failures of the Current Process: 1. BUS does not communicate any other system (various systems contain same data) 2. Business resources needed to manage BUS 3. Lack of workflow for Case Management process 4. No utilization of SalesForce to bring in data from CBMS, EPSDT and Client contact center 5. Unable to use case management system for Meaningful Use (can't track client trends in functional abilities) 6. Lack of a central data system for PAR generation and submission	
Notes:	

Establish Case – CM01

Manage Case Information – CM02

CO MITA 3.0 SS-A Project

Business Area: Care Management
Business Category: Case Management
Business Process: Manage Case Information
Author(s): Nikki Lemmon, Barb Rydell, Jerry Smallwood, Beth Martin, Kevin Dunlevy-Wilson, Hela Sahli, Dawn McGlasson, Gina Robinson, Sean Bryan
Facilitator: Christine Rohrer
Actor(s): Client, Family Members, Provider, Case Managers, Case Management Agencies, Department Staff, Other State Agencies (e.g., DOE, DHS), Nursing Facilities, Home Health Agencies, Physician Offices, HCBS Providers, Community Organizations, Advocacy Agencies, Fiscal Agent, CMS, PPL

MITA 3.0 Business Process Description:
The **Manage Case Information** business process uses state-specific criteria and rules to ensure appropriate and cost-effective medical, medically-related social and behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as:
• Medicaid Waiver program case management
• Home and Community-Based Services (HCBS)
• Other agency programs
• Disease management
• Catastrophic cases
• Early Periodic Screening, Diagnostic, and Treatment (EPSDT)
  o Well care visits, oral health visits, lead testing, developmental screening, depression screening
• Immunizations for children and adults
The **Establish Case (CM01)** business process (part of the Care Management business area) creates each individual case and treatment plan.
The **Manage Case Information** business process includes activities to confirm delivery of services and compliance with the plan. It also includes activities such as:
• Service planning and coordination
• Facilitation of services (e.g., finding providers, or establishing limits or maximums)
• Advocating for the client
• Monitoring and reassessment of services for need and cost effectiveness
  o This includes assessing the client's placement and the services received and taking necessary action to ensure that services and placement are appropriate to meet the client's needs.
The Health Information Exchange (HIE) provides health information and clinical records for client and care coordination with provider, pharmacist, and other agencies.

Manage Case Information – CM02

CO Business Process Description:
Colorado's **Manage Case Information** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- Eligibility for programs and the initial treatment plan have been established (except for EPSDT) (Eligibility for EPSDT: All children and youth ages 20 and under with current eligibility as well as all pregnant women).

***Trigger(s)*:**

1. Treatment plan has been approved, and/or change in condition has been identified
2. Acute care episode
3. Regularly scheduled review
4. EPSDT eligibility

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

		to meet client needs
	M	**END:** Services are monitored and adjusted as necessary
		CDASS
1.	M	**START**: Case manager **performs** review of service plan according to established rules
2.	M	Case manager **updates** functional assessment, if necessary
3.	M	If change in condition or change in service plan is warranted, Case Manager will **revise** the service plan and the Prior Authorization request
4.	M	*Service Monitoring (continuous process):* Case Manager **follows** HCBS QIS protocol for service monitoring
5.	M	**Monitor** client's ability to manage their budget
6.	M	**END:** Services are monitored and adjusted as necessary
		EPSDT
1.	M	**START**: Family Health Coordinator **initiates** contact with the clients to educate them about benefits (based on MMIS claims information or follows up on clients who have not accessed services in more than 12 months, or completes the annual reminder 12 months from the original eligibility determination date
2.	M	Family Health Coordinator **addresses** any issues or concerns brought up during the contact
3.	M	Family Health Coordinator **monitors** the MMIS data to determine eligible clients who have not received services (quarterly)
4.	M	Family Health Coordinators **contact** the clients on the report
5.	M	Family Health Coordinators **find** resources in the community (medical or non Medicaid needs are both covered)
6.	M	Family Health Coordinators **conduct** community outreach (WIC, HCP, housing, food banks, domestic violence, etc.)
7.	M	Family Health Coordinators **conduct** client outreach
8.	M	Family Health Coordinators **assist** client with medical and non-medical case management
9.	M	Family Health Coordinators **conduct** missed appointment follow-up
10.	M	Family Health Coordinators **record** all contacts with the eligible population as well as contacts with other providers or community services accessed on behalf of the family. This could include uploading documents into the system needed for case management.
11.	M	**END**: Family Health Coordinator **works** with other federally funded public health programs, as required

Outcome:

1. Client receives or continues to receive appropriate support and care in a timely manner and meets federal requirements of 80% of children and youth receiving well care, 2 oral health visits per year, appropriate lead testing, developmental screening and depression screening as outlined in Bright Futures and other Colorado periodicity schedules as

developed.	
As Is Performance Metrics: • The State Medicaid Agency (SMA) updates cases within the timeframe specified by state policy. • Movements towards desired health care outcomes because of improvements in case management practices • QIS measures • Surveys • Retrospective reviews ***Supporting Performance Metrics/SLA Documentation:*** • N/A	***To Be Performance Metrics:*** • QIS measures • Surveys • Retrospective reviews • Monitor timeliness of case management
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS 3. BUS 4. CBMS 5. CCMS 6. CMS - MDS 7. PPL 8. ASPEN 9. COLD 10. New EPSDT data system 11. TRAILS 12. EPSDT data to counties	***Shared Data/Interfaces, Outbound*:** 1. TRAILS 2. EPSDT data to counties 3. COLD
To Be Future Vision: 1. Hospitalization, ER visit, new chronic condition, multiple chronic conditions, etc., trigger alert to case manager 2. Care coordination for all children and pregnant women regardless of health status (currently happens for EPSDT) 3. 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 4. PACE encounters 5. System integrated, internal performance measures 6. Satisfaction surveys for clients, with results available in DSS 7. Interface between Case Management Software (BUS) and MMIS/DSS 8. Disease management program 9. Catastrophic cases program 10. MMIS needs to be able to support the EPSDT program (regardless of the department	

that may run the program
11. Near real-time data reporting

Failures of the Current Process:

1. Case Managers authorize more services than needed
2. Lack of standardization
3. No PACE encounters
4. No internal reliability and validity for current assessment process
5. No utilization of the SalesForce systems to allow all programs that use it (CBMS, Client Contact Center, Healthy Communities) to have a complete picture of case management and contacts with the family/household
6. Case managers case loads are too heavy to effectively monitor clients
7. No way to add providers or community resource referrals to the BUS for tracking purposes
8. Understaffed in terms of State oversight
9. Staff turnover (lacking knowledge retention)
10. 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.
11. Lack of centralized and integrated data for case management

Notes:

CO MITA 3.0 SS-A Project

Business Area: Care Management
Business Category: Case Management
Business Process: Manage Population Health Outreach
Author(s): Nikki Lemmon, Barb Rydell, Jerry Smallwood, Beth Martin, Kevin Dunlevy-Wilson, Hela Sahli, Dawn McGlasson
Facilitator: Christine Rohrer
Actor(s): All stakeholders who have an interest in community health
MITA 3.0 Business Process Description: The **Manage Population Health Outreach** business process is responsible for the implementation of strategy to improve general population health. The State Medicaid Agency (SMA) identifies target populations or individuals for selection by cultural, diagnostic, or other demographic indicators. The inputs to this business process are census, vital statistics, immigration, and other information sources. This business process outputs materials for: • Campaigns to enroll new members in existing health plan or health benefit • New health plan or health benefit offering • Modification to existing health plan or health benefit offering It includes production of information materials and communications to impacted members, providers, and contractors (e.g., program strategies and materials, etc.). The communication of information includes a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). ***CO Business Process Description:*** Colorado's **Manage Population Health Outreach** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Interest in improving community health
Trigger(s): 1. Clients and potentially eligible population in need of health improvement, services, education, intervention, etc. 2. Health initiatives/promotions 3. Policy changes 4. Process improvement 5. Problem identified with current process 6. Benefit expansion initiatives 7. Health promotion to existing population

Manual (M) or Automated (A)	***Steps:***

1.	M	**START: Obtain** stakeholder input
2.	M	**Identify** target areas/groups
3.	M	**Determine** most effective way to provide information
4.	M	**Determine** area of state with high eligible, but not enrolled, population
5.	M	**END: Provide** the information

Outcome:
1. Identification of risk indicators
2. Healthier population
3. Improved access to, utilization of, and knowledge of services

As Is Performance Metrics:
- Waiver or state plan amendment – Must notify public within X days
- Rules – must have public input and perform outreach within X days

Supporting Performance Metrics/SLA Documentation:
- N/A

To Be Performance Metrics:
- Same as As-Is
- Measure impact or success of outreach efforts

Shared Data/Interfaces, Inbound:
1. CDPHE
2. CDC
3. Individual surveys of specific populations (i.e., CAHPS)
4. Census data
5. Vital stats (birth and death data)
6. State and national surveys
7. Internal and external stakeholders
8. Local public health departments
9. County commissioners
10. Schools (manual)

Shared Data/Interfaces, Outbound:
1. Schools (manual)
2. External HCPF website
3. PEAK website
4. Internal and external stakeholders
5. Local public health departments
6. County commissioners
7. CDPHE
8. To reach clients: email, PowerPoints, mailings, other media
9. Provider Web Portal via MMIS

To Be Future Vision:
1. Sharing data
2. Access to data in a timely manner
3. Ability to identify Medicaid population within data sets
4. Multilingual
5. Electronically communicate with clients in the community (e.g., text, mobile access, email)
6. Increased ability to target potentially eligible clients and existing clients, based on demographic data

Failures of the Current Process:
1. No access to accurate demographics for sub-populations, including Medicaid 2. Lack of outreach and education tools 3. Lack of coordination between State agencies and within State agencies 4. Lack of stakeholder management and engagement 5. Inability to identify the right populations 6. Inability to address population health, including identification of sub-groups 7. Lack of cultural competency
Notes:

CO MITA 3.0 SS-A Project

Business Area: Care Management		
Business Category: Case Management		
Business Process: Manage Registry		
Author(s): Diana Laube, Hela Sahli, Barbara Rydell, Jerry Smallwood, Meredith Henry, Gina Robinson, Rene Horton		
Facilitator: Christine Rohrer		
Actor(s): Providers, Clients, Community Partners, CDPHE, MCO		
MITA 3.0 Business Process Description: The **Manage Registry** business process receives a member's health outcome information, prepares updates for a specific registry (e.g., immunizations, cancer, disease) and responds to inquiries with response information. In the context of MITA, a medical registry consolidates related records from multiple sources (e.g., intrastate, interstate or federal agencies) into one comprehensive data store. This data store may or may not reside within the Medicaid information system. ***CO Business Process Description:*** Colorado's **Manage Registry** business process is generally aligned with the MITA 3.0 Framework.		
Precondition: • A registry is implemented		
Trigger(s): 1. Immunization event is recorded and a scheduled file cycle occurs		
Manual (M) or Automated (A)		***Steps:***
		Operating a Registry:
1.	M	**START:** 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	Department staff **post** data files from query results to CIIS via CDPHE's secure FTP site
3.	M	CIIS staff **obtain** files from secure FTP site
4.	M	**END**: CIIS staff **load** files into registry, cleaning data for duplicates and/or other errors
		Response to Inquiry:
1.	A	**Start**: CIIS **accepts** and **processes** MCO request files (including data validation, quality review and duplication processing)
2.	A	Processing results are **provided** to the MCO for analysis

3.	M/A	**END**: CIIS **provides** results or outbound file that indicates if there is a matching record between the MCO's file and CIIS • If yes, the results file provides immunization history for the client • If multiple matches are returned, CIIS staff will select the best possible match and include any immunization history for the client
		Providing Access to Authorized Parties:
1.	M	**START**: **Request** for registry access is received
2.	M	CIIS staff **reviews** and **determines** if the request is from an authorized and specified entity
3.	M	Only if requesting agency has been approved, CIIS staff **determines** if the requestor is covered under the existing approval
4.	M	If not previously approved, the appropriate authorizing mechanism is **established** (Letter of Agreement, Login Request Form, Delegation Agreement, Confidentiality Form, etc.)
5.	M	**END**: CIIS staff reviews and approves access as applicable

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

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. CIIS: External Administrative Database 2. CDPHE secure FTP 3. MMIS 4. DSS	***Shared Data/Interfaces, Outbound*:** 1. CDPHE secure FTP 2. MCOs

To Be Future Vision:
1. Automated MMIS data warehouse data reports
2. Automate the process used to identify duplicate records.
3. Add Developmental screening to the IZ registry

Failures of the Current Process:
1. Manual processes
2. Lack of knowledge transfer
3. Connectivity issues with CDPHE's secure FTP
4. Maintaining current CDPHE FTP software on HCPF machines

Notes:

CO MITA 3.0 SS-A Project

Business Area: Care Management

Business Category: Case Management

Business Process: Perform Screening and Assessment

Author(s): Diana Laube, Hela Sahli, Barbara Rydell, Jerry Smallwood, Meredith Henry

Facilitator: Christine Rohrer

Actor(s): Case Manager, Client, Care Management Team, Providers, CDHS, Family Members, Nursing Facilities, Home Health Agencies, Advocacy Agencies

MITA 3.0 Business Process Description:

The **Perform Screening and Assessment** business process is responsible for the evaluation of client's health information, facilitating evaluations and recording results. This business process assesses for certain health and behavioral health conditions (e.g., chronic illness, mental health, substance abuse), lifestyle and living conditions (e.g., employment, religious affiliation, living situation) to determine risk factors. This business process:

- Establishes risk categories and hierarchy, severity, and level of need
- Screens for required fields
- Edits required fields
- Verifies information from external sources if available
- Establishes severity scores and diagnoses
- Associates with applicable service needs

Health Information Exchange (HIE) verifies a client's health information.

CO Business Process Description:

Colorado's **Perform Screening and Assessment** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- Case is established

Trigger(s):

Interaction-based Trigger Events:

1. Receive new client enrollment alert from **Establish Case (CM01)** business process
2. Receive redetermination of client enrollment alert from **Establish Case (CM01)** business process

Manual (M) or Automated (A)		***Steps:***
1.	M	**START: Receive** new member or redetermination of client enrollment from **Establish Case (CM01)** business process
2.	M	Case manager **gathers** information for history and/or examinations

3.	M	Case manager **determines** risk factors and establish risk categories
4.	M	Case manager **conducts** needs assessment and determines level of need
5.	M	Case manager **determines** health benefits that are appropriate for the client
6.	M	**Staff** records screening and assessment results
7.	M	Case manager **refers** client to applicable services based on results
8.	M	**END**: **Send** alert to notify client of applicable services based on screening and assessment

Outcome:
1. Client notified of applicable services as needed
2. Service providers notified of referred client
3. Obtain tracking information as needed for measuring performance and business activity monitoring

As Is Performance Metrics:	***To Be Performance Metrics:***
• Hospital-based referrals must be conducted within 2 full business days of receipt of the complete referral • Nursing facility referrals must be completed within 5 full business days of the complete referral • Community-based referrals require completion of the assessment within 10 full business days of confirmation of the county eligibility office in which an application is in process or financial eligibility already exists ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. Health Information Exchange (HIE) data store including health information, clinical record and clinical data 2. Plan data store including policy information 3. Health Benefit data store including program and service information 4. Case History data store including action lists, journal notes, reviews and approvals 5. BUS 6. MMIS 7. DSS 8. SalesForce (feeds into CBMS) 9. CBMS 10. CCMS	***Shared Data/Interfaces, Outbound***: 1. BUS 2. CCMS

11. CMS 12. PPL 13. ASPEN 14. COLD 15. New EPSDT data system 16. TRAILS 17. SIS Online	
To Be Future Vision: 1. Centralized database 2. One assessment process that is standardized across programs	
Failures of the Current Process: 1. Case Manager and Care Management Team is unable to acquire history and/or examination information 2. Information must be entered in multiple locations, leading to errors and duplication of effort	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Care Management

Business Category: Case Management

Business Process: Manage Treatment Plans and Outcomes

Author(s): Diana Labe, Taylor Larsen, Kevin Dunlevy-Wilson, Barbara Rydell, Hela Sahli

Facilitator: Christine Rohrer

Actor(s): Clients, Families, Case Management Agencies, Case Managers, Providers, UM Vendors, Advocacy Organizations, Community Organizations, CDHS, Department Staff, HIE, RCCOs

MITA 3.0 Business Process Description:
The **Manage Treatment Plan and Outcomes** business process uses federal and state specific criteria and rules to ensure that the providers/contractors chosen and services delivered optimizes member and member population outcomes. It includes activities to track and assess effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors. It also includes ongoing monitoring, management, and reassessment of services and treatment plans for need, appropriateness, and effectiveness, and monitoring of special member populations (e.g., pregnant women and children, and HIV/intravenous drug users). Health Information Exchange (HIE) monitors a member's health information.

CO Business Process Description:
Colorado's **Manage Treatment Plans and Outcomes** business process generally aligns with the MITA 3.0 Framework.

Precondition:
- Receive Inbound Transaction
- Establish Case
- Authorize service Plan

Trigger(s):
1. Receipt from Health Information Exchange (HIE) of a modification in client's health outcome
2. Reassess service plan from Manage Case Information business process
3. Periodic review of client's service plan is due
4. Receive request to review client's service plan

Manual (M) or Automated (A)		***Steps:***
1.	M	**START: Receive** client's service plan from **Establish Case (CM01)** business

		process (part of the Care Management business area)
2.	M	**Review** of effectiveness of the services, service plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors
3.	M	**Determine** if modifications are necessary for effective treatment outcome
4.	M	**Send** notification to client, provider, and other care coordinators of modification in treatment or benefits
5.	M	**END: Record** required modifications to client's service plan
		Alternate Path
1.	A	**START: Receive** treatment plan from Health Information Exchange (HIE**)**
2.	M	**Review** of effectiveness of the services, treatment plan, providers/contractors, service planning and coordination, episodes of care, support services, and other relevant factors
3.	M	**Determine** if modifications are necessary for effective treatment outcome
4.	M	**Record** required modifications to client's treatment plan
5.	M	**Send** notification to client, provider, and other care coordinators of modification in treatment or benefits
6.	M	**END**: Send modification to client's treatment plan or benefits to Health Information Exchange (HIE)

***Outcome*:**

1. Client's treatment or service plan and outcomes are appropriate for their needs.
2. Make modification (e.g., creates, update, delete) to client's treatment or service plan
3. Updated treatment plan sent to Health Information Exchange (HIE)
4. Client, provider and care coordinators notified of modifications in treatment or service plan or benefits.
5. Tracking information as needed for measuring performance and business activity monitoring.

As Is Performance Metrics:	***To Be Performance Metrics:***
• Quality Improvement Strategy • Claims data to inform whether client receives services in treatment plan/service plan • 372 (Waivers. Review utilization and outcomes. Is sent to CMS.) • Waivers require a minimum of a 6-month review ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Quality Improvement Strategy • 372 (Waivers. Review utilization and outcomes. Is sent to CMS.) • Waivers require a minimum of a 6-month review
Shared Data/Interfaces, Inbound: 1. BUS	***Shared Data/Interfaces, Outbound*:**

2. Log notes can be added to the BUS 3. Health Information Exchange (HIE) data store including health information, medically-related social and support services, clinical record, and clinical data 4. Case History data store including action lists, reviews, and approvals 5. Claims data (MMIS) 6. CCMS	1. HIE 2. Email 3. FTP sites 4. Add log notes to BUS only 5. MMIS
To Be Future Vision: 1. Centralized database to reduce errors, duplication of effort 2. Report directly from centralized database 3. Increased automation	
Failures of the Current Process: 1. Case managers cannot access claims data or other database information (waivers)	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Care Management
Business Category: Authorization Determination
Business Process: Authorize Referral
Author(s): Marceil Case, Michelle Miller
Facilitator: Christine Rohrer
Actor(s): Provider, Client, Specialist, UM Vendor
MITA 3.0 Business Process Description: The **Authorize Referral** business process is responsible for referrals between providers that the State Medicaid Agency (SMA) approves for payment, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. The SMA uses this business process primarily for Primary Care Case Management programs where additional approval controls deemed necessary by the state. Most States do not require this additional layer of control. **NOTE:** MITA contains three (3) different authorization business processes: 1. **Authorize Service (CM08)** (part of the Care Management business area) – the standard process of prior authorization of services. 2. **Authorize Treatment Plan (CM09)** (part of the Care Management business area) – the approval of a treatment plan prepared by a care management team in a care management setting. 3. **Authorize Referral** – specifically the approval of a referral to another provider, requested by a primary care physician. The **Authorize Referral** business process may encompass both a pre-approved and post-approved referral request, especially in the case where the member required immediate services. This business process may include, but is not limited to, referrals for specific types and numbers of visits, procedures, surgeries, tests, drugs, durable medical equipment, therapies, and institutional days of stay. The SMA evaluates requests based on urgency, state priority requirements, and type of service/taxonomy (durable medical equipment, speech, physical therapy, dental, inpatient, out-of-state). It validates key information, and ensures that the referral is appropriate and medically necessary. After review, staff approves, modifies, suspends for additional information or denies the request. This business process sends an alert to **Manage Case Information (CM01)** business process (part of the Care Management business area). A post-approved referral request is an editing/auditing function that requires review of

information after the referral is complete. A review may consist of verifying documentation to ensure that the referral is appropriate, and medically and/or functionally necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the Process Claim or Process Encounter business processes.

CO Business Process Description:
Colorado's **Authorize Referral** business process is generally aligned with the MITA 3.0 Framework. In Colorado, there are are multiple other managers/vendors involved in prior authorization requests and referral requests. These include Behavioral Health Organizations (BHO) that perform referrals/PARs, transportation PARs, Pharmacy PARs, for example.

Precondition:

- Clients in Fee for Service Medicaid do not require referrals to see a specialist. PARs may be required for some specialty services.
- If client is in Fee for Service Medicaid and enrolled in the Client Over-Utilization Program (COUP) then they must have referral to specialist made by the client's Primary Care Provider
- If client is enrolled in a managed care plan or a BHO, then all covered services are managed through that managed care entity

***Trigger(s)*:**

1. Client presents with a need for a service that requires a referral

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START: Receive** request for referral
2.	M	**Schedule** appointment with Specialist
3.	M	Specialist **requests** confirmation of referral from COUP primary care
4.	M	**END**: **Receive** Medicaid number from COUP provider for the Specialist to include with billing statements

***Outcome*:**

1. Service can be provided
2. Specialist can be reimbursed

As Is Performance Metrics:	***To Be Performance Metrics:***

• APS must complete all non-urgent PARs with a Turn Around Time (TAT) of 4 business days. Urgent requests get a TAT of 2 business days. Emergent services do not require a PAR.
• Weekly and monthly status meetings with APS
• At a minimum, weekly and monthly metrics from APS to verify our Service Level Agreements (SLA):
  ○ TAT (see times above)
  ○ All PAR services approved, denied, partially
	• Same as As-Is

denied, % denial. Technical denials cannot exceed 10% of all requests. o Inbound calls, penetration, speed of answer o Nurse Advice Line call data average abandonment rate cannot exceed 5%, call rate of 5% of clients annually • Vendor website incident reports ***Supporting Performance Metrics/SLA Documentation:*** • *N/A*	
Shared Data/Interfaces, Inbound: 1. MMIS 2. CGI Web Portal 3. PDCS (pharmacy) 4. DSS	***Shared Data/Interfaces, Outbound***: 1.
To Be Future Vision: 1. Interface that allows electronic confirmation of referrals 2. Improved referral confirmation number (currently the PCP provider's ID) 3. Link originating provider to specialist they are referring 4. Care coordination repository 5. Improve client monitoring and outcomes. (Much of this occurs in the ACC program, for enrolled clients) 6. Editing/auditing on other provider numbers that come in on claims (e.g., NPI for all provider fields)	
Failures of the Current Process: 1. No ability to edit 2. Inconsistent claims adjudication on referrals (e.g., claims don't deny without referral) 3. No ability to audit 4. Lack of accurate provider status (e.g., no longer eligible) 5. Non-compliant clients (e.g., don't want PCP)	
Notes: Regarding Prior Authorizations (PAR) by APS: • APS performs PARs for medical necessity • APS is not part of the PCP/specialist referral process • APS does complete the majority of prior authorization requests for services such as Audiology, Dental, Diagnostic Imagine, DME, Medical, Long Term Home Health, PT/OT/ST, Habilitative, (some) Transportation, Vision, etc.	

CO MITA 3.0 SS-A Project

Business Area: Care Management
Business Category: Authorization Determination
Business Process: Authorize Service
Author(s): Barb Rydell, Kevin Dunlevy-Wilson, Hela Sahli, Nathan Culkin, Diana Labe, Jerry Smallwood, Tim Cortez
Facilitator: Nicole Wong
Actor(s): Providers, Clients, Authorizing Agents (external to Department), Department Staff (cost containment), Utilization Management Vendor, Case Management Agencies, Fiscal Agent
MITA 3.0 Business Process Description: The **Authorize Service** business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. Its primary use is in a fee-for-services setting. Prior authorization of a service request is a care management function and begins when a case manager or provider requests a service request by mail, facsimile, telephone, or Accredited Standards Committee (ASC) X12 278 Health Care Services Review Information request transaction. The case manager or UM vendor evaluates requests based on state rules for prioritization such as urgency and type of service/taxonomy (e.g., durable medical equipment, speech, physical therapy, dental, and out-of-state), validates key information, and ensures that requested service is appropriate and medically necessary. After review staff, Fiscal Agent, or UM vendor approves, modifies, denies or suspends for additional information the service requests. The State Medicaid Agency (SMA) sends the appropriate response information for the outbound ASC X12 278 Health Care Services Review Response transaction to the provider using the **Send Outbound Transaction**. **NOTE:** MITA contains three (3) different authorization business processes: 1. **Authorize Service** – the standard process of prior authorization of services. 2. **Authorize Treatment Plan (CM09)** (part of the Care Management business area) – the approval of a treatment plan prepared by a care management team in a care management setting. 3. **Authorize Referral (CM07)** (part of the Care Management business area) – specifically the approval of a referral to another provider, requested by a primary care physician. A post-approved service request is an editing/auditing function that requires review of information after the service is complete. A review may consist of verifying documentation

to ensure that the services were appropriate and medically necessary, and validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the **Process Claim (OM07)** or **Process Encounter (OM29)** business processes (part of the Operations Management business area).

NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, and Off-label use of drugs, Social Service, Experimental Treatments, Out-of-State Services, HCBS, and Emergencies.

CO Business Process Description:
Colorado's **Authorize Service** business process is generally aligned with the MITA 3.0 Framework. However, it does not include the level of detail regarding the prior authorization process.

Precondition:

- Client presents with a need for a service that requires authorization
- Level of care identified

***Trigger(s)*:**

1. Request is submitted by case manager or provider

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START:** Provider or case manager **initiates** and **submits** initial or revised request (PAR)
2.	M/A	**Review** of PAR by the authorizing agency to ensure it meets established criteria
3.	M/A	**Submit** PAR and PAR decision by the authorizing agency to the Fiscal Agent * Steps 1-3 reviewing agency determines M or A, depends on service
4.	M	**END**: **Generate** letter to provide client, provider, or case manager of the PAR decision
		Steps for LTC Nursing facilities: (Some PARS are submitted electronically and some are submitted manually)
1.	M	**START:** Case Management Agency **receives** request/inquiry from nursing facility or hospital
2.	M	Case Management Agency **determines/verifies** eligibility and level of care
3.	M	Case Management Agency **notifies** the County and Nursing Facility that the client is functionally eligible for the level of care
4.	M	Nursing Facility **creates** Plan of Care
5.	M	Nursing Facility **submits** 5615 to the County and the Case Management Agency

6.	M	**END:** Authorizing Agency **delivers** PAR to Fiscal Agent – (Automated) 320 byte proprietary transaction

Outcome:
1. Client is approved/denied to receive services

As Is Performance Metrics:	***To Be Performance Metrics:***
• Decision within 10 business days of PAR request for HCBS (state requirement) • The Home Health Agency shall submit the formal written prior authorization request to the Department or its designated review entity within 10 working days of the "from" date on the Home Health plan of care or within 10 working days of the end of the client's Acute Home Health period or current Long Term Home Health PAR. • The prior authorization request shall be reviewed by the Department or its designated review entity to determine compliance with Medicaid rules, and shall be approved, denied, or returned for additional information within 10 working days of receipt. The PAR shall not be backdated to a date prior to the 'from' date of the HCFA-485. Services may be approved retroactively for no more than 10 days prior to the PAR submission date • Prior authorization requests shall be submitted and may be approved for up to a one-year period. Approve, deny, or request additional information for prior authorization requests based on Department policy within ten (10) business days of receipt. • Refer all unusual PARs, as defined by the Department, to the appropriate Department or Department staff for review within two (2) days of receipt. • Process all approved and denied PARs received from the Department within five (5) business days of receipt. • Generate and make available letters and appropriate forms responding to telephone, fax, or written requests for PARs of services within twenty-four (24) hours. • Respond to providers' requests for the status of a PAR within twenty-four (24) hours • Provide access to the electronic data transmission	• Greater accuracy to reduce rejected PARS • Number of days to process PARS

subsystem to receive electronic PARs twenty-three (23) hours per day (downtime limited for routine maintenance to the hours of 4:00 a.m. to 5:00 a.m. daily) seven (7) days per week. ***Supporting Performance Metrics/SLA Documentation:*** • N/A	
Shared Data/Interfaces, Inbound: 1. BUS Service Plan, LTC 803 2. MMIS 3. CCMS (DD) 4. 5615 5. CBMS 6. PAR forms 7. CarewebQI 8. DSS	***Shared Data/Interfaces, Outbound*:** 1. MMIS to CGI Web Portal 2. BUS Service Plan, LTC 803 3. CCMS (DD) 4. 5615 5. CBMS 6. PAR forms 7. CarewebQI 8. DSS
To Be Future Vision: 1. Everything to be electronic; eliminate paper 2. Minimal manual processes 3. Direct (electronic) interfaces between ALL authorizing vendors and MMIS 4. Near real-time information 5. Auto PAR approval 6. Single sign-on for providers 7. All PARs submitted through a web interface 8. Centralized access to all information relating to review and approval of PARs 9. Real-time emergency department (ED) authorizations similar to systems used in private sector 10. MMIS / DSS tracking of real-time ED authorizations	
Failures of the Current Process: 1. Too many applications to sign into 2. Too much paper 3. Too much manual intervention 4. Too many vendors 5. ED services not PARed similar to other private insurance 6. Not using standardized electronic transactions 7. Multiple PAR forms	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Care Management
Business Category: Authorization Determination
Business Process: Authorize Treatment Plan
Author(s): Barb Rydell, Kevin Dunlevy-Wilson, Hela Sahli, Nathan Culkin, Diana Lambe, Jerry Smallwood, Tim Cortez
Facilitator: Nicole Wong
Actor(s): 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)

MITA 3.0 Business Process Description:

The **Authorize Treatment Plan** business process encompasses both a prior authorization and post-approved treatment plan. The State Medicaid Agency (SMA) uses the **Authorize Treatment Plan** primarily in the care coordination setting where the care management team assesses the member's needs, decides on a course of treatment, and completes the treatment plan.

NOTE: MITA contains three (3) different authorization business processes:

1. **Authorize Service (CM08)** (part of the Care Management business area) – the standard process of prior authorization of services.
2. **Authorize Treatment Plan (CM09)** (part of the Care Management business area) – the approval of a treatment plan prepared by a care management team in a care management setting.
3. **Authorize Referral (CM07)** (part of the Care Management business area) – specifically the approval of a referral to another provider, requested by a primary care physician.

A treatment plan prior-authorizes the named providers or provider types and services or category of services. The SMA prior authorizes individual providers for the service or category of services, and they do not have to submit their own prior authorizations or service requests. A treatment plan is typically a schedule of medical, therapeutic, and /or psychological procedures and appointments that span a length of time designed to restore a patient's specific health condition. In contrast, the SMA limits an individual service request, primarily associated with fee-for-services payment, to focus on a specific visit, services, or products (e.g., a single specialist office visit, approval for a specific test or particular piece of Durable Medical Equipment (DME)).

The prior authorized treatment plan generally begins with the receipt of an **Authorize**

Treatment Plan request from the care management team. The SMA staff then evaluates it based on urgency, state priority requirements, and type of service/taxonomy (speech, physical therapy, home health, behavioral, social), and validates key information, and ensures that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, staff approves, modifies, suspends for additional information or denies the request. Business process sends an alert to **Manage Case Information (CM01)** business process (part of the Care Management business area).

A post-approved treatment plan is an audit function that reviews suspended or paid claims to ensure the services were appropriate and in accordance with the treatment plan.

CO Business Process Description:
Colorado's **Authorize Treatment Plan** business process is generally aligned with the MITA 3.0 Framework. However, it does not include the level of detail regarding the prior authorization process.

Precondition:
- Indication of LTC need

***Trigger(s)*:**
1. Referral to Case Management Agency

Manual (M) or Automated (A)		***Steps:***
1.	M	**START:** Case Management Agency **receives** request/inquiry
2.	M	Case Management Agency **determines/verifies** eligibility and level of care
3.	M	Case Management Agency **creates and authorizes** (or seeks Department approval for) a Service Plan
4.	M	Case Management Agency **enters** Service Plan into Benefits Utilization System (BUS)
5.	M/A	Case Management Agency **submits** a PAR to the Fiscal Agent * CCB Case Management **submits** a PAR in DDD Web, which is transmitted to the Fiscal Agent
6.	M/A	**END**: Fiscal Agent **enters** PAR into the MMIS (not applicable for CCBs)

***Outcome*:**
1. Authorized Service Plan
2. Provider is authorized to start services
3. Client receives appropriate services in appropriate amount, scope and duration

As Is Performance Metrics:
- N/A

Supporting Performance Metrics/SLA Documentation:
- N/A

To Be Performance Metrics:
- Greater alignment between authorized services and actual services provided
- Reduction in critical incidents

Authorize Treatment Plan – CM09

Shared Data/Interfaces, Inbound:	***Shared Data/Interfaces, Outbound:***
1. BUS 2. MMIS 3. CCMS (DD) 4. 5615 5. ULTC 100.2 6. PASRR Results (Pre-Admission Screening and Resident Review – feeds into the treatment plan) 7. CBMS 8. PAR forms	1. BUS 2. ULTC 100.2 3. CBMS 4. PASRR 5. 5615
To Be Future Vision: 1. MMIS integration with Case Management database (replace the BUS) 2. Bi-directional integration of MMIS with Eligibility Determination Systems 3. Interface with Vital Stats 4. All transactions to be HIPAA compliant (remove proprietary and paper based PAR transactions) 5. Ability to accept all (electronic) attachments 6. Better coordination between case management agency and county 7. Conflict free case management 8. Standardization of transactions, with the ability to edit appropriately 9. Better reporting data (i.e. for authorization service vs. used services) 10. Audit support 11. Electronic revision of PARS 12. Improved client needs/functional assessment tool (ULTC 100.2) 13. Capture instances where a change in client status results in additional or different services (in near real time) 14. Access to historical client data 15. Greater alignment between authorized services and actual services provided	
Failures of the Current Process: 1. Extended Timelines to authorize PARs and treatment plans 2. Human error associated with paper-based PAR transactions 3. BUS and MMIS communication is only one-way (no MMIS→BUS feedback loop) 4. Too many PAR revisions – would like a better way of managing PARS 5. PAR number changes with revision 6. Delayed confirmation/verification of financial eligibility causing delays in the provision of necessary services	
Notes:	

4 – Eligibility and Enrollment Management Use Cases

Determine Member Eligibility – EE01

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management
Business Category: Member Enrollment (Future Release)
Business Process: Determine Member Eligibility
Author(s): Alex Stephens, Tom Whalen, Vicki Foreman, Brian Knight, Ama Lucaci, Kirstin Michel, Kim Nguyen, Marceil Case, Jon Meredith, Carol Shuford, Jerry Smallwood
Facilitator: Amy Mazeski
Actor(s): Eligibility Workers (counties, DHS, MA sites and PE sites), Operational Contractor, OIT (data center and business process owner for CBMS), Eligibility Division at HCPF (business requirements owner), CMS, CHP+, Enrollment Broker, Case Management Agencies
MITA 3.0 Business Process Description **(CMS Draft Release July 2013):** The **Determine Member Eligibility** business process is responsible for the operational aspects of determining if an applicant is eligible for Medicaid or potentially eligible for other insurance affordability programs (e.g., Advance Premium Tax Credits through the Health Insurance Marketplace, Children's Health Insurance Program (CHIP), and/or Basic Health Program (BHP)). An applicant submits an application or a member updates account information via online, in person, over the phone, by mail, or by other commonly available electronic means. The business process checks for status (e.g., new, resubmission, redetermination, duplicate, or referral from the Health Insurance Marketplace (HIX) or other agencies administering insurance affordability programs) and verifies applicant information in accordance with the policies established. The business process determines eligibility based on modified adjusted gross income (Modified Adjusted Gross Income (MAGI)) or on a basis other than MAGI methods including group/category (e.g., parents/caretaker relatives, pregnant women, children under 19 year of age). The business process also assigns a Medicaid ID, associates the benefit packages, and produces notifications for coordinated communications. When required, the State Medicaid Agency (SMA) submits applicant or member eligibility information and/or eligibility determination to other agencies administering insurance affordability programs and CMS information systems. This business process could be a Shared Eligibility Service between the Medicaid Agency, the Health Insurance Marketplace (HIX), and other State-based insurance affordability programs such as CHIP or BHP. NOTE: Applications and Accounts: An individual seeking eligibility for enrollment in an insurance affordability program completes and submits an application on-line, in person, over the phone, by mail, or paper application for verification and eligibility determination.

Determine Member Eligibility – EE01

Accepted application data is managed in an "electronic account" (as defined in 42 CFR 435.4) by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes.

CO Business Process Description:
Colorado's **Determine Member Eligibility** business process generally aligns with MITA 3.0, except that it does not currently interface with the HIX.

In addition, client eligibility is determined using CBMS, a shared system, used by HCPF/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 application or redetermination

***Trigger(s)*:**

1. Original eligibility application data set
2. On-going case maintenance (EDBC)
3. Interfaces that feed into CBMS (for clients who are automatically eligible)
4. Scheduled Event: Time for Redetermination
5. Change in case data
6. Changes from a legislative action (i.e., statutes, rule changes)

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Enter** eligibility application data into CBMS
2.	A	**Assign** Case Number
3.	M/A	**Verify** status of application (new, on-going, or redetermination)
4.	A	**Validate** syntax and semantic requirements associated with eligibility application a. Business rules **identify** fatal and non-fatal errors and associated error messages
5.	M/A	**Validate** completeness and required fields a. Business rules **identify** mandated fields and apply edits
6.	M/A	**Verify** eligibility documentation for disability, pregnancy, applicant resources, etc.
7.	A	**Assign** State Medicaid I.D.
8.	A	**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, **assign** eligibility category(ies) a. **Notify** client of eligibility status via system generated letter b. If ineligible, **provide** denial reason and process for appeals via system generated letter **i.** System generated report is sent to Connect For Health Colorado to determine if client meets criteria for other insurance subsidies
9.	A (CBMS)	**Request** that the **Manage Applicant and Member Communication (ME02)** business process, which is contained within the Member Management business area, generate notifications to head of the household/authorized rep
10.	A	**Upload** eligibility information from the eligibility interface into MMIS
11.	A	**Assign** eligibility type in the MMIS
12.	A	**Associate** benefit packages in MMIS 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*:**

1. Eligibility is determined in CBMS and sent to MMIS

As Is Performance Metrics:	***To Be Performance Metrics:***
• Time to complete process = 45 days, 90 days if they have a disability determination • Accuracy of information = 95% • Accessibility of information for creating solicitation = Real time • Consistency of decisions and disposition = _We do not calculate an error rate for the counties. For PERM, CMS calculates an error rate for the Department. • Error rate = 5% or less • **CBMS User Data Transfer to C4HCO from PEAK** o When a Medicaid application from PEAK is denied, failed, terminated, or discontinued for any individual, CBMS will generate a SSAp for all individuals on the case and send it to C4HCO through the OIT Gateway for further processing.	• Time to complete process = 10 days for receipt of information • Accessibility of information for creating solicitation = Real Time • Consistency of decisions and disposition = Same as As-Is

○ *Medical Assistance Applications/Cases Successful and Failed Transmissions to C4HCO – Ad hoc* • **CBMS Interface to C4HCO** ○ When a Medicaid application not from PEAK is denied, failed, terminated, or discontinued for any individual, CBMS will generate a SSAp for all individuals on the case and send it to C4HCO through the OIT Gateway for further processing. ***Supporting Performance Metrics/SLA Documentation:*** • N/A	
Shared Data/Interfaces, Inbound: 1. TRAILS (system of record for foster care) determines eligibility for the foster care system and merges with CBMS records and inputs into MMIS 2. Benefits Utilization System (BUS) (CBMS) (shared data, manual process) 3. SVES SCHIP 4. IEVS Wage 5. SDX 6. BENDEX 7. PARIS 8. NDNH 9. SOLQ-I 10. SVES 11. MMIS 12. DSS 13. CMS 14. CCART 15. Mental Health Database 16. Eligibility Inquiry Tools (i.e., Web Portal, faxback, AVERS) 17. DMV 18. SSI Feed	***Shared Data/Interfaces, Outbound*:** 1. Connect for Health Colorado 2. Enrollment Brokers 3. SDAC Vendor 4. Recovery Vendors 5. UM Vendor 6. CIVHC
To Be Future Vision: 1. Send pended and denied records from CBMS to MMIS 2. Centralized access to all information relating to review and approval of PARs	

3. Bi-directional communication from MMIS to CBMS
4. Electronic application submission
5. Interface with state and national validation sources to identify fraud, waste and abuse (vital statistics, IRS, corrections)
6. Solve privacy issues with data sharing to allow for comprehensive data interfaces (as indicated above)
7. Interface with address correction/update service to obtain up-to-date client contact information so client communications can be successfully completed
8. Maintain historical eligibility data within MMIS

Failures of the Current Process:

1. Current system does not have a centralized location for all PAR reviewers to have access to eligibility and benefit package information
2. Delay in a decision, backdating eligibility
3. Delay in a decision, load letter not accepted by provider
4. HCPF must translate CBMS information outside of either system into legacy MMIS values
5. 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
6. MMIS data edits must be done manually in CBMS; with multiple players making it difficult to correct data in a timely manner
7. Updated record from CBMS replaces data in MMIS
8. Managing data in two systems with one way feed creates data integrity issues
9. Human error
10. No access to vital statistics and similar data sources to automatically validate/populate data
11. Difficult or impossible to locate/contact clients who have moved

Notes:

Enroll Member – EE02

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management
Business Category: Member Enrollment (Future Release)
Business Process: Enroll Member
Author(s): Alex Stephens, Tom Whalen, Vicki Foreman, Brian Knight, Ana Lucaci, Kirstin Michel, Kim Nguyen, Marceil Case, Jon Meredith, Carol Shuford, Jerry Smallwood, Doug Van Hee, Sarah Roberts
Facilitator: Amy Mazeski
Actor(s): CBMS, MMIS, PDCS, DSS, BUS, Department Staff, TRAILS
MITA 3.0 Business Process Description (CMS Draft Release July 2013): The **Enroll Member** business process receives eligibility information from the **Determine Member Eligibility (EE01)** business process (part of the Eligibility and Enrollment Management business area), the Marketplace, or any insurance affordability program (e.g., Children's Health Insurance Program (CHIP) or Basic Health Program (BHP)). It determines additional qualifications for enrollment in health benefits for which the member is eligible, and produces notifications for coordination of communications to the member, provider, and to the insurance affordability programs. The Marketplace, Agency or enrollment brokers may perform some or all of the steps in this business process. NOTE: There is a separate business process for **Disenroll Member (EE03)** (part of the Eligibility and Enrollment Management business area). NOTE: Applications and Accounts: An individual seeking eligibility for enrollment in a qualified health plan through the Marketplace, advance premium tax credits, cost-sharing reductions, Medicaid, CHIP or BHP completes and submits an on-line, telephone, in-person, or paper application for verification and eligibility determination. The Marketplace or insurance affordability program accepts application data and manages information in an "account" by the receiving program to enable access to this information during the verification and eligibility determination processes, as well as after the conclusion of the process to support change reporting and for other purposes. ***CO Business Process Description:*** Colorado's **Enroll Client** business process generally aligns with MITA 3.0, except that it does not currently interface with the HIX. This process excludes Managed Care, which is covered in the Care Management Business Area.
Precondition:

- Eligibility data has been received for eligible clients

***Trigger(s)*:**
1. Eligibility file that accompanies initial or redetermination of eligibility

Manual (M) or Automated (A)		***Steps:***
1.	A	**START**: **Receive** client eligibility data from the **Determine Member Eligibility (EE01)** business process (part of the Eligibility and Enrollment Management business area)
2.	A	**Process** eligibility data required for benefit package determination
3.	A	**Generate** eligibility assignment data and **load** into MMIS
4.	A	MMIS **assigns** benefits for Medical claims and Pharmacy claims
5.	A	MMIS **notifies** relevant vendors/systems
6.	A	**END: Notify** client of enrollment

***Outcome*:**
1. Client is assigned to benefit package and notified of enrollment

As Is Performance Metrics:	***To Be Performance Metrics:***
• Enrollment broker contract requires that the broker "shall input all client choices into MMIS within two (2) business days. ***Supporting Performance Metrics/SLA Documentation:*** • Enrollment broker contract	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. MMIS 2. CBMS 3. TRAILS 4. Other eligibility tools required for inquiries	***Shared Data/Interfaces, Outbound*:** 1. PDCS 2. DSS 3. SDAC 4. Web Portal

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

Failures of the Current Process:

1. 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
2. No process for notifying and reconciling errors identified by MMIS error reports within CBMS
3. Required fields missing or not correct — Request additional or corrected information from client or **Determine Member Eligibility (EE01)** business process (part of the Eligibility and Enrollment Management business area)
4. EOMB are sent to the wrong clients, or contains wrong information (I.e. eligibility spans, demographic information, etc.)
5. Human error
6. Antiquated MMIS system; doesn't allow for implementation of new rules or validation to assure proper demographics
7. Difficult or impossible to locate/contact clients who have moved
8. Assignment of too many clients to a singular eligibility type

Notes:

Disenroll Member – EE03

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management
Business Category: Member Enrollment (Future Release)
Business Process: Disenroll Member
Author(s): Steve Hunter, Terry Bussert, Brian Knight, Christine Martinez, Dianne Hinricher, Ana Lucaci, Kevin Dunlevy-Wilson, Alex Stephens, Marceil Case, Carol Shuford, Kim Nguyen
Facilitator: Amy Mazeski
Actor(s): Counties, MA Sites, Eligibility Sites, State Staff, Clients, SEPS (single entry point LTC case management agencies), Program Performance, Fiscal Agent, Medicaid Enrollment Broker, CHP+ Eligibility and Enrollment Vendor
MITA 3.0 Business Process Description (Draft Release July 2013): The **Disenroll Member** business process is responsible for the termination of a member's enrollment in a health plan or health benefit. An enrollment termination may occur due to: • A member is no longer eligible based on redetermination of Medicaid eligibility either on an annual basis or as a result of change reporting during the coverage year • Upon receipt of a notification of incarceration, SMA may suspend eligibility (if State policy indicates to do so) • A member is no longer eligible based on change in residence • The denial of eligibility for a program that bases eligibility on health status (e.g., an AIDS Drug Assistance Program (ADAP), Home and Community Based Services, a Maternity Case Management, etc.) NOTE: The other program may have a funding source separate from Medicaid • A member submits a disenrollment request • Disenrollment request from a provider or contractor due to issues with the member such as moving out of service area, fraud and abuse, disruptive behavior, non-compliance, or death • Member is deceased • Receive disenrollment request from **Manage Compliance Incident Information (PE03)** business process (part of the Performance Management business area) for continued failure to make payments • Receive disenrollment request from **Determine Adverse Action Incident (PE04)** business process (part of the Performance Management business area) due to fraudulent or abuse activity • The provider or contactor has a change of status or termination that requires a mass disenrollment of members • A health plan or health benefit has a change that requires a mass disenrollment of members

- A member modifies their Manage Care Organization (MCO), Primary Care Case Manager
- (PCCM), or waiver provider:
  - Member changes information during Open Enrollment period
  - As permitted by State rules, such as the following:
    - Change in member's residence
    - A provider whom the member has chosen no longer contracts with current program or MCO
    - Medicaid terminates the contract with the member's MCO or PCCM
    - Member successfully appeals auto-assignment
    - The member has issues with the MCO, PCCM, or waiver provider that may affect quality of care

NOTE: Enrollment brokers/vendor may perform some of the steps in this business process.

CO Business Process Description:
Colorado's **Disenroll Client** business process generally aligns with MITA 3.0.

Note: Counties, MA Sites, Eligibility Sites may perform some of the steps in this process.

Precondition:

- Enrolled in Medicaid; application is completed and received
- Enrolled in a health plan; client has been determined eligible for a program that meets health plan enrollment criteria

***Trigger(s)*:**

1. Death
2. Client request
3. Provider request (for health plans only)
4. Change in financial situation
5. Change in residence
6. Change in function
7. Change in age
8. Determine client eligibility business process (i.e., redetermination)
9. Staff audit
10. Identification of other insurance (for CHP+ only)

Manual (M) or Automated (A)		***Steps:***
		Long Term Supports and Services (LTSS) Waiver Services:
1.	M	**START**: **Perform** functional assessment
2.	M	**Determine** change in function and eligibility information
3.	M	**Enter** information in BUS and send to CBMS
4.	M	**Pass** information through interface from CBMS to MMIS (eligibility file)

5.	M	**END**: **Load** information into MMIS
		Change in Eligibility Information:
1.	M	**START**: **Enter** new information in CBMS and/or TRAILS
2.	A	**Pass** information through the interface from CBMS to MMIS (eligibility file)
3.	A	**END**: **Upload** information to MMIS
		Manual Client Disenrollment:
1.	M	**START**: **Locate** Client information in the MMIS
2.	M	**Update** necessary information in the MMIS to reflect appropriate action
3.	M	**END**: Save Disenrollment information in the MMIS
		Automated Client Disenrollment:
1.	A	**START**: **Receipt** of change in eligibility information from CBMS
2.	A	**Reassessment** of current managed care enrollment for the client
3.	A	**END**: **Apply** appropriate end date and disenrollment reason codes

Outcome:

1. Client is disenrolled from the health plan and/or previous MMIS eligibility status is overwritten in MMIS

As Is Performance Metrics:	***To Be Performance Metrics:***
• Termination of Enrollment in a health plan (this information is online) ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Managed care health plan enrollments are terminated prior to the next capitation run
Shared Data/Interfaces, Inbound: 1. MMIS 2. BUS 3. CBMS 4. CMS 5. CGI (Web Portal) 6. COBC 7. TRAILS	***Shared Data/Interfaces, Outbound***: 1. Recovery Vendors 2. DSS 3. CMS 4. CGI (Web Portal) 5. CBMS

To Be Future Vision:

1. Need audit trail in MMIS
2. Save history in MMIS
3. 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
4. 2-way interface between CBMS and MMIS

5. Workflow management for information entry in CBMS (to ensure MMIS gets data it needs) 6. Help function/tutorial within MMIS 7. More editing capabilities on the MMIS side 8. Data load validation – kick incorrect values to error file for validation, before populating in MMIS 9. Improved client education on Medicaid redetermination process 10. MMIS shall allow manual enrollment/disenrollment as required 11. Implement a flexible system that allows Managed Care enrollment specialist to assign Foster Care Clients as needed (with appropriate justification) 12. MMIS process based on near-real time information from CBMS 13. Capacity to suspend client eligibility rather than terminate when client is involved in the criminal justice system
Failures of the Current Process: 1. No audit trail due to overwriting of eligibility status in MMIS from CBMS 2. Incorrect values received from CBMS are loaded into MMIS without validation 3. 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 had this problem updating the Client enrollment/disenrollment with these 999 enrollment spans 4. Clients that are active in TRAILS and CBMS, the CBMS data is not transmitted to MMIS, thus losing critical data
Notes:

Inquire Client Eligibility – EE04

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management
Business Category: Member Enrollment (Future Release)
Business Process: Inquire Client Eligibility
Author(s): Steve Hunter, Terry Bussert, Brian Knight, Christine Martinez, Diane Hinricher, Ana Lucaci, Kevin Dunlevy-Wilson, Alex Stephens, Marceil Case, Carol Shuford, Kim Nguyen, Julie Collins
Facilitator: Amy Mazeski
Actor(s): Providers, Health Plans, Counties, State Staff, Fiscal Agent, CHP+ Vendor, Medicaid Enrollment Broker, UM Vendor
MITA 3.0 Business Process Description (CMS Draft Release in July 2013): The **Inquire Member Eligibility** business process receives requests for eligibility verification from Health Insurance Marketplace (HIX), authorized providers, programs or business associates; performs the inquiry; and prepares the Eligibility, Coverage or Benefit Information response. The response information includes but is not limited to benefit status, explanation of benefits, coverage, effective dates, and amount for co-insurance, co-pays, deductibles, exclusions and limitations. The information may include details about the Medicaid health plans, health benefits, and the provider(s) from which the member may receive covered services. NOTE: This business process does not include Member requests for eligibility verification. Client initiated requests are handled by the **Manage Member Information (ME01)** business process (part of the Member Management business area). ***CO Business Process Description:*** Colorado's **Inquire Client Eligibility** business process generally aligns with MITA 3.0, except that it does not currently interface with the HIX. In addition, 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.
Precondition: • Need for eligibility verification
Trigger(s): 1. Request for services 2. Request for eligibility

Inquire Client Eligibility – EE04

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Authorized user (i.e., State staff, Fiscal Agent or UM Vendor) **receives** request for eligibility verification
2.	M/A	**Search** MMIS for client eligibility, if authorized
3.	M	**END**: **Response** provided
		Alternate Sequence – Automated request through Web Portal, CMERS, or Fax Back:
1.	M/A	**START**: **Request** eligibility verification
2.	A	**END**: **Response** returned

Outcome:

1. Eligibility verified

As Is Performance Metrics:	***To Be Performance Metrics:***

• Performance measures 1D1 and 1D2:
  ○ Percent of All New Applications (FY2012-13 Actual = 94%, Target = 95%)/ Redeterminations (FY2012-13 Actual = 93%, Target=95%) for Medical Assistance that Meet Timely Processing Requirements; 1B12 Percent of Medicaid clients that receive timely pre natal care = FY12-13 77.5%; Performance measure VI.A.5 Percent of Clean Claims Paid Timely (Within 90 Days) FY12-13=99.98%
• Performance Measure 1C4:
  ○ Achieve the Annual Budgeted Net Savings Amount for the Accountable Care Collaborative = FY12-13 ($6,300,000); Performance measure 1C5: Percent of Medicaid Provider Payments Linked to Value-Based Outcomes = FY2012-13 1.65%; Performance measure 1C6: Number of Regional Care Collaborative Organizations that Achieve Level 1 Pay for Performance Savings for All Key Indicators = FY2012-13 0; VI.A.2 Maximum Cash Fund Balance from Hospital Provider Fee at End of Fiscal Year as a Percent of Estimated Expenditures for Health Coverage Expansions; Performance measure IVA1 Percent of General Fund Expenditures for Department Administration = FY12-13 3%;
	• FY12-13 Target for timely eligibility processing measures = 95%; FY12-13 Target for 1B12 = 80.3%
	• IC4 FY 2013-14 Target=$12,000,000; 1C5 2013-14 Target = 2.00%; 1C6 = TBD; VIA2 2013-14 Target = 5%; IVA1 FY13-14 Target TBD;
	• 1B12 2014 Target = 80.3%; 1E5 2014 Target = 12

Performance measure VB3: Return on Investment from Implemented LEAN Projects in Estimated Equivalent Dollars (actuals TBD this is a new measure) • Performance measure VB3: ○ Return on Investment from Implemented LEAN Projects in Estimated Equivalent Dollars (actuals TBD this is a new measure); VI.A.2 Maximum Cash Fund Balance from Hospital Provider Fee at End of Fiscal Year as a Percent of Estimated Expenditures for Health Coverage Expansions; • Performance measure 1E5 Number of Adult Core Medicaid Quality Measures Reported = FY 12-13 10; Performance Measure 1E4 Percent of CAHPS Global Ratings Measures at or above National Medicaid Average for Adults in the Colorado Medicaid Program = FY12-13 50% ***Supporting Performance Metrics/SLA Documentation:*** • Department Performance Plan	
Shared Data/Interfaces, Inbound: 1. MMIS 2. CBMS 3. TRAILS 4. AVRS 5. Fax Back 6. Web Portal 7. UM Vendor	***Shared Data/Interfaces, Outbound***: 1. DSS 2. Fax Back 3. Web Portal 4. UM Vendor
To Be Future Vision: 1. New eligibility system 2. New MMIS 3. New DSS 4. Consistent eligibility responses across all platforms 5. Capture retro eligibility and ineligibility 6. More flexibility in modification of ETL between CBMS and MMIS and between MMIS and DSS 7. Data load validation (testing/staging environment) – kick incorrect values to error file for validation, before populating in MMIS 8. Ensure eligibility spans have a beginning and an end date in response	

9. Return every eligibility type in response 10. Appropriate staff to have access to web portal 11. Specify copayment information across all programs (i.e., CHP+)
Failures of the Current Process: 1. Human error 2. Misinterpretation through web portal 3. Inconsistent eligibility responses from different systems may cause confusion 4. 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 5. Inability to specify copayment information across all programs (CHP+)
Notes:

Determine Provider Eligibility – EE05

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management		
Business Category: Provider Enrollment		
Business Process: Determine Provider Eligibility		
Author(s): Christine Chavez, Evan Grimes, John Aldag, Marceil Case, Matt Miville, Daniel Bea, Laurie Stephens, Brian Knight, Ryan Martin, Kim Nguyen, Diane Hinricher, Erick Croy, Alex Stephens, Ana Lucaci, Cathy Traugott, Carol Reinboldt, Jerry Smallwood, Jon Meredith		
Facilitator: Amy Mazeski		
Actor(s): Requestors, Fiscal Agents, State Staff (including DHS), DPHE, DORA		
MITA 3.0 Business Process Description (Draft Release July 2013): The **Determine Provider Eligibility** business process works in conjunction with Medicare and the processing of dual eligibles. Medicare agency conducts provider screening activities, application fee collection, and revalidation for those providers who serve dual eligibles. **Determine Provider Eligibility** business process is responsible for the provider screening activities, application fee collection, and revalidation for only Medicaid providers. NOTE: External contractors such as quality assurance and credentialing verification services may perform some of these steps. ***CO Business Process Description:*** Colorado's **Determine Provider Eligibility** business process generally aligns with the MITA 3.0 Framework. Note that the current revalidation process is minimal and not systematic.		
Precondition: • Receive Inbound Transaction		
Trigger(s): Receipt of provider enrollment application		
Manual (M) or Automated (A)		***Steps:***
1.	M	**START:** Health care provider **completes** and **submits** an enrollment application
2.	M	Provider **identifies** whether they are currently participating in Medicare
3.	M	**Receive** enrollment application and other pertinent enrollment communication information
4.	M	**Validate** enrollment application data and ensure application is complete
5.	M	**END:** If validation fails, **notify** provider, **request** missing or incomplete

		information, and **pend** application
6.	M/A	**Determine** submission status by querying provider data in the MMIS. Application status may be initial, resubmitted with modification, or duplicate a. If resubmitted application, response contains only updated information and process skips irrelevant step below b. **END**: If duplicate application, application is returned to provider
7.	M	**Determine** applicant type/Provider taxonomy (e.g., primary, rendering, pay to, billing, or other)
8.	M	**Determine** enrollment eligibility (e.g., accepted, denied, or pended) based on federal and state rules
9.	M	**Determine** if there are enrollment caps due to moratoriums issued. If yes, skip to step 12
10.	M	If Medicaid accepts enrollment application, **begin Enroll Provider** business process (EE06 - part of the Eligibility and Enrollment Business Area)
11.	M	If Medicaid denies the enrollment application for Provider, **begin Disenroll Provider (EE07)** business process (part of Eligibility and Enrollment Business Area) to deny provider enrollment
12.	M	**END: Send** enrollment eligibility determination and **begin Manage Provider Communication (PM02)** business process (part of the Provider Management Business Area) to send relevant information to provider
		Alternate Sequence:
1.	M	**Determine Provider Eligibility** business process results in a denial or suspension of an enrollment eligibility request for reasons such as: • Provider fails to meet screening requirements • Provider fails to meet state enrollment requirements • National Plan and Provider Enumeration System (NPPES) or any other national enumeration systems cannot enumerate Health Care Provider

Outcome:

1. Agency accepts, denies, or suspends the provider's application
2. Begin **Enroll Provider (EE06)** business process (part of the Eligibility and Enrollment Management business area)
3. If applicable, begin **Disenroll Provider (EE07)** business process (part of the Eligibility and Enrollment Management business area) to remove provider from services
4. Notify provider via **Manage Provider Communication (PM02)** business process (part of the Provider Management Business Area) of enrollment eligibility determination
5. Tracking information as needed for measuring performance and business activity monitoring

As Is Performance Metrics:	***To Be Performance Metrics:***

• The fiscal agent is allowed 8 business days to process applications if no state approval is required ***Supporting Performance Metrics/SLA Documentation:*** • Service Level Agreement – MMIS contract	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. CMS 2. Provider data store including application information (NPI, Provider demographics, Provider taxonomy) 3. NPI and provider demographics exchanged with the National Plan and Provider Enumeration System (NPPES) and any other national enumeration systems 4. Provider sanction information from: • The OIG or the General Accounting Office (GAO) sanction lists of individuals, vendors, and/or suppliers excluded from participation in Medicare, Medicaid, and other federally funded Sate programs from databases such as the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS) • State Provider Licensing Authority (DORA, DPHE) • Healthcare Integrity and Protection Data Bank (HIPDB) data store • National Practitioner Databank (NPDB)	***Shared Data/Interfaces, Outbound***: 1. Enrollment outcome (approval/denial) letter mailed (USPS) to provider (per Enroll Provider process) 2. Program Integrity notification if license issues

• State Prescription Monitoring Program (PMP) 5. Tax identifiers: Employer ID Number (EIN), Social Security Number (SSN), Taxpayer Identification Number (TIN) from applicant and verified with tax identifier verification sources and any other information required for Form 1099 production 6. Disclosure information including: • Information on ownership and control • Information on family relationships of owners • Information related to business transactions • Information on managing employees • Information on persons convicted of crimes • Disclosure by providers and managed care entities. 7. Multiple office locations, pay to addresses, business associates, and key contract personnel CMS caps and limits moratorium information 8. Insurance Affordability Program data store including eligibility and enrollment information	
To Be Future Vision: 1. Automated provider enrollment process, which is compliant with CMS provider screening rules 2. A provider directory 3. More automation, less manual processes	
Failures of the Current Process:	

Determine Provider Eligibility – EE05

1. Most of the current process is manual 2. Does not comply with the CMS provider screening rules
Notes:

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management
Business Category: Provider Enrollment
Business Process: Enroll Provider
Author(s): Christine Chavez, Evan Grimes, John Aldag, Marceil Case, Matt Miville, Daniel Bea, Laurie Stephens, Brian Knight, Ryan Martin, Kim Nguyen, Diane Hinricher, Alex Stephens, Ana Lucaci, Cathy Traugott, Carol Reinboldt, Jerry Smallwood, Jon Meredith
Facilitator: Amy Mazeski
Actor(s): Fiscal Agent, Providers, Department Staff, DHS, CDPHE, DORA
MITA 3.0 Business Process Description (Draft Release July 2013): The **Enroll Provider** business process is responsible for enrolling providers into Medicaid, which includes: 1. Determination of contracting parameters (i.e., Provider taxonomy, type, category of service that the Provider can bill) 2. Establishment of payment rates and funding sources, taking into consideration service area, incentives or discounts 3. Initiate **Manage Provider Information (PM01)** (part of the Provider Management business area) business process to enter initial and modified enrollment information, including Providers contracted with program contractors into the Provider data store 4. Initiate **Manage Provider Information (PM01)** business process (part of Provider Management business area) to make enrollment information available to all parties and affiliated business processes, including: 5. To prepare Provider Electronic Funds Transfer (EFT) or check with the **Manage Accounts Payable Disbursement (FM14)** business process (part of Financial Management business process) ***CO Business Process Description:*** Colorado's **Enroll Provider** business process is generally aligned with that described in the MITA 3.0 Framework. Note that Colorado does not perform numbers 4 or 5 from the above list. In addition, external contractors such as a quality assurance and credentialing verifications services may perform some of these steps.
Precondition: • New enrollment
Trigger(s): <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

Environmental Trigger Event - Receipt of scheduled prompt of user request for:
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)		***Steps:***
1.	M	**Start: Receive** enrollment application
2.	M	**Validate** application [If validation fails, process terminates – see Failures]
3.	M	**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.	A	**Assign** Medicaid ID
5.	M	**Enter** application information into MMIS
6.	M	**Determine** applicant type/provider taxonomy (i.e., primary, rendering, pay to, billing, other)
7.	M	**Assess** enrollment type to determine appropriate required verification
8.	M	**Verify** information on the enrollment application or record with internal and external sources, including enumerators, sanction status, credentials
9.	M	Fiscal Agent **approves** application if no State approval is needed
10.	M	**Determine** State approval and rates, if required. Includes identifying type of rate (i.e., negotiated, Medicare, percent of charges, case management fee, other via look-ups in the reference and benefit repositories)
11.	M	**Submit** and **communicate** approved/denied status via transmittal for State reviewed applications
12.	A	**End**: **Send** approval or denial letter to the provider via the **Manage Provider Communication (PM02)** business process (part of the Provider Management business area)
13.	M	**Optional**: Ongoing information is available for providers on the Department's external website

***Outcome*:**
1. The Provider is enrolled or denied
2. The MMIS is updated and enrollment data required for operations is available
3. The Provider is notified about enrollment results

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A	• N/A

Supporting Performance Metrics/SLA Documentation: • N/A	
Shared Data/Interfaces, Inbound: 1. TPMS – manual & automated 2. COFRS/CORE - automated 3. Web portal - manual & automated 4. DORA - manual on initial enrollment 5. National Plan and Provider Enumeration System (NPPES) - manual process 6. OIG 7. OSCAR database (CLIA) – manual on enrollment 8. LEIE 9. ASPEN – DPHE – manual process 10. SAVE verification – manual process	***Shared Data/Interfaces, Outbound*:** 1. COFRS/CORE - automated 2. Web portal - manual & automated 3. PDCS
To Be Future Vision: 1. Reevaluate enrollment based on performance measures or triggered by date such as anniversary date based on Medicaid policy to verify data based on a contractual duration (i.e.. year or months) 2. Provider enrollment information updated back to TPMS and DPHE (to update web portal & notify DPHE of enrollment status) 3. ACC and provider enrollment process in MMIS 4. 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 5. Online enrollment for providers, including zip code validation 6. Some degree of automation 7. National sharing database 8. Require providers to update information through the provider portal 9. Require providers to update / confirm address and other contact information at least annually via provider portal 10. Family Health Coordinators need access to the provider portal 11. 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 12. Enroll providers based on NPI rather than using legacy provider IDs 13. Expand access to provider information	
Failures of the Current Process: Process Failure: Enrollment application processing terminates or suspends due to: 1. Duplicate applications 2. Lost or missing information due to human error 3. The responsibility for determining provider type requirements has moved from one	

department to another (some institutional knowledge has been lost) 4. Family Health Coordinators don't have access to which providers are enrolled Medicaid providers, and are not notified when a new provider is enrolled 5. Provider contact information outdated / incorrect 6. There is no established systematic revalidation process (not compliant with Provider Screening Rules)
Notes: Marceil will do further analysis on the Alternate sequence (removed from end of business process steps above) below and incorporate applicable information into this 'notes' section. **Alternate Sequence:** M - **Approve** Medicaid provider M/A - **Review** ACC or PCPP application if submitted M/A - **Execute** contract for ACC or PCPP

Disenroll Provider– EE07

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management
Business Category: Provider Enrollment
Business Process: Disenroll Provider
Author(s): Evan Grimes, Richard Delaney, Kim Nguyen, Dianne Hinricher, Brian Knight, Matt Miville, Christina Chavez, Laurie Stephens, Ryan Martin, Daniel Bea, Alex Stephens
Facilitator: Amy Mazeski
Actor(s): Providers, Fiscal Agent, Department Staff, DHS
MITA 3.0 Business Process Description (Draft Release July 2013): The **Disenroll Provider** business process is responsible for managing disenrollment in the Medicaid Program. This business process covers the activity of disenrollment including the tracking of disenrollment requests and validation that the disenrollment meets the State's rules. Medicaid sends notifications to affected parties (e.g., provider, contractor, business partners), as well as alerts to other business processes to discontinue business activities. ***CO Business Process Description:*** Colorado's **Disenroll Provider** business process is generally aligned with that described in the MITA 3.0 Framework.
Precondition: • Enrolled provider
Trigger(s): Receipt of a disenrollment request, or modification or cancellation of a request, along with associated data (i.e., reason for disenrollment, effective date): • Requested by the provider • Requested by another Business Process (i.e., the **Manage Provider Communication (PM02)** business process (part of the Provider Management business area), business processes from the Performance Management business area, the **Manage Case Information (CM02)** business process (part of the Care Management business area)) • Due to receipt of information about a provider's death, retirement, or disability from the **Manage Provider Communication (PM02)** or **Manage Provider Information (PM01)** business processes ((respectively) part of the Provider Management business area)

Manual (M) or Automated (A)		***Steps:***
1.	M	**Start: Receive** disenrollment request
2.	M	**Determine** if provider type requires State approval for disenrollment
3.	M	If yes, **see** alternate sequence

4.	M	**Contact** provider to verify termination request
5.	M	**Determine** if provider had any paid claims after requested date of termination
6.	M	If yes, **contact** provider regarding paid claim. If voluntary termination, 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.	M	**Determine** if provider has an outstanding AR balance with Department. If yes, report to accounting
8.	M	**Submit** provider disenrollment request to fiscal agent (includes: provider number, termination date)
9.	M	**Enter** termination information to internal spreadsheet. This spreadsheet tracks the termination reason, which is not tracked in MMIS
10.	M	Fiscal agent **completes** termination
11.	M	**End:** Department staff **verify** that termination was completed in MMIS
		Alternate Sequence:
1.	M	State staff **reviews** provider request. After approval, **generates** Disenrollment request for fiscal agent
2.	M	**Submit** termination request to fiscal agent through transmittal
3.	M	**Determine** if provider had any paid claims after requested date of termination
4.	M	If yes, **contact** provider regarding paid claim. If voluntary termination, 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.	M	**Determine** if provider has an outstanding AR balance with Department; if yes, report to accounting

***Outcome*:**
1. Provider is terminated

As Is Performance Metrics:	***To Be Performance Metrics:***
• The fiscal agent is allowed 5-8 business days to process transmittals ***Supporting Performance Metrics/SLA Documentation:*** • Service Level Agreement – MMIS Contract	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. Medicare or other state 2. OIG 3. Adverse action (e.g. DORA license process, Appeal outcomes)	***Shared Data/Interfaces, Outbound*:** 1. Accounting Department

To Be Future Vision:
1. Share termination data with Public Health, TPMS, and provider portal
2. Automate letter to notify provider of both involuntary and voluntary termination

3. Capture termination reason in MMIS 4. Allow provider to self-disenroll and remove from provider portal 5. More automation, less manual processes
Failures of the Current Process: Disenrollment processing terminates due to: 1. Human error 2. Lost data
Notes:

Inquire Provider Information – EE08

CO MITA 3.0 SS-A Project

Business Area: Eligibility and Enrollment Management		
Business Category: Provider Enrollment		
Business Process: Inquire Provider information		
Author(s): Evan Grimes, Richard Delaney, Kim Nguyen, Dianne Hinricher, Brian Knight, Matt Miville, Christina Chavez, Laurie Stephens, Ryan Martin, Daniel Bea, Alex Stephens		
Facilitator: Amy Mazeski		
Actor(s): PCPP, Client, Provider, Fiscal Agent, State Staff, Case Managers, Contractors		
MITA 3.0 Business Process Description (Draft Release July 2013): The **Inquire Provider Information** business process receives requests for provider enrollment verification from authorized providers, programs or business associates, and performs the inquiry and prepares the response information for the **Send Outbound Transaction**. ***CO Business Process Description:*** The **Inquire Provider Information** business process is generally aligned with that described in the MITA 3.0 Framework.		
Precondition: • Identified need for information		
Trigger(s): 1. Receipt of a request for provider enrollment verification		
Manual (M) or Automated (A)		***Steps:***
1.	M	**START:** Department **receives** request for verification
2.	M/A	**END: Respond** to request for verification
3.	M	Fiscal agent **identifies** the requesting provider via NPI, SSN, EIN to verify match to enrolling provider (FA will not provide information to any other entity, e.g. clients, another provider, etc.)
Outcome: 1. Verification response received by requestor		
As Is Performance Metrics: • Department SOP requires return response to phone calls/emails within 2 business days • Fiscal agent call center has SLA requirement not to exceed 5% abandonment rate on incoming provider		***To Be Performance Metrics:*** • Same as As-Is

Inquire Provider Information – EE08

phone calls ***Supporting Performance Metrics/SLA Documentation:*** • HCPF SOP • Service Level Agreement – MMIS Contract	
Shared Data/Interfaces, Inbound: 1. Provider Portal 2. MMIS 3. DSS	***Shared Data/Interfaces, Outbound*:** 1. Provider Portal
To Be Future Vision: 1. Ability to search by provider type in MMIS 2. Ability to search providers by language capability 3. Multilingual search capabilities 4. Provider directory generation capabilities 5. More information for clients (i.e. office hours, whether accepting new clients, etc.)	
Failures of the Current Process: 1. Incorrect or out of date data 2. Not all provider types loaded on provider portal look up mechanism 3. Human error	
Notes:	

5 – Financial Management Use Cases

Manage Provider Recoupment–FM01

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Receivable Management
Business Process: Manage Provider Recoupment
Author(s): Cathy Fielder, Jocelyn Parker, Diana Labe, Eileen Sandoval, Sharon Brydon, Ashley Dirienzo, Souzan Auran, Bailey Perkins, Sandy Salus, Ryan Martin, Laurie Stephens, Greg Tanner, Erick Croy, Sam Seligman, Ben Drendel, Dianne Hinricher, Daniel Beg, Kim Nguyen
Facilitator: Nicole Wong
Actor(s): TPL Contractor, Program Integrity, Accounting, Benefits Coordination, Fiscal Agent Operations, Fiscal Agent, Audits, MFCU (Medicaid Fraud Control Unit), Provider
MITA 3.0 Business Process Description: The **Manage Provider Recoupment** business process manages the determination and recovery of overpayments that were paid to providers in error. The State Medicaid Agency (SMA) initiates provider recoupment upon the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where provider owes monies to the SMA due to fraud or abuse. The business thread begins with discovering the overpayment, then retrieving claims payment information, initiating the recoupment request, or adjudicating a claims adjustment request, and notifying the provider of audit results via the **Manage Provider Communication (PM02)** business process (part of the Provider Management Business Area), applying recoupments in the system via the **Manage Accounts Receivable Information (FM06)** business process (part of the Financial Management Business Area), and monitoring payment history until the provider satisfies the repayment. The SMA collects recoupments via check sent by the provider or credited against future payments for services. ***CO Business Process Description:*** Colorado's **Manage Provider Recoupment** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Overpaid claim
Trigger(s): 1. Identification of overpayment

Manage Provider Recoupment–FM01

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: Department identifies or receives overpayment notification
2.	M/A	**Validation** of overpayment
3.	M/A	**Initiate** recovery process with provider, OR
4.	M/A	**Transmittal** to fiscal agent
5.	A	MMIS **performs** adjudication
6.	A	**Recovery** through financial cycle or direct provider payment via check
7.	M/A	**END: Record** revenue

***Outcome*:**
1. Overpayment is recovered

As Is Performance Metrics:	***To Be Performance Metrics:***
• Program Integrity: 30 days to pay back from date of demand letter. Timeframe may be extended through the appeals process. • Federal Regulation: Federal Funds must be returned and reported on the CMS-64 in the quarter in which payment was received from the provider • Recovery within 60 days from date of identification (TPL Recovery) ***Supporting Performance Metrics/SLA Documentation:*** • 42 CFR 433.300 through 433.322	• Federal Funds must be returned and reported on the CMS-64 in the quarter in which payment was received from the provider • Accounts Receivable setup within 3 business days of submitting the accounts receivable to the fiscal agent
Shared Data/Interfaces, Inbound: 1. DSS 2. MMIS 3. COFRS (implementing CORE – new financial system July 2014) 4. CBMS 5. Web Portal 6. COAD (Colorado Authoritative Document) 7. Trackwise (transmittals) 8. TPL Contractor	***Shared Data/Interfaces, Outbound*:** 1. TPL Contractor 2. Recovery Contractor 3. COAD 4. Trackwise (transmittals)

To Be Future Vision:
1. Automate revenue recording process
2. Additional automation, minimize paper transactions (currently fiscal agent hand-keys data) – e.g. Trackwise transmittals and COAD. If the financial system could pass adjustments directly (bi-directional) to the MMIS for provider recoupment.

3. Claims need to be “marked” or “coded” so subsequent audits can see previously recovered claims. 4. Automation of demand letter generation 5. Avoidance of duplicate retraction (e.g. same claim, same client, same DOS, same provider, same condition) 6. Increased timeliness with new MMIS – automate initiation of recoupment once identified within MMIS (business rule)
Failures of the Current Process: 1. Human error 2. Data from eligibility system overwrites historical MMIS data 3. 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. 4. Data error affecting identification of recoupment (e.g. CHAMP VA)
Notes:

Manage TPL Recovery – FM02

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Receivable Management
Business Process: Manage TPL Recovery
Author(s): Cathy Fielder, Jocelyn Parker, Diana Lambe, Eileen Sandoval, Sharon Brydon, Ashley Dirienzo, Souzan Auran, Bailey Perkins, Sandy Salus, Ryan Martin, Laurie Stephens, Greg Tanner, , Sam Seligman, Ben Drendel, Dianne Hinricher, Daniel Beg, Kim Nguyen
Facilitator: Nicole Wong
Actor(s): Clients, Providers, Counties, TPL Contractor, Insurance Carriers, Program Integrity, Fiscal Agent, Personal Injury Attorneys, and Benefits Coordination
MITA 3.0 Business Process Description: The **Manage TPL Recovery** business process begins by receiving Third-Party Liability (TPL) information from various sources such as external and internal information matches, tips, referrals, attorneys, compliance management incident, Medicaid Fraud Control Unit (MFCU), providers, and insurance companies. The business process: • Identifies the provider or TPL carrier, locates recoverable claims • Creates the coordination of benefits file • Creates post-payment recovery files • Sends notification to other payer or provider from the **Manage Provider Communication (PM02)** business process (part of Provider Management business area) ***CO Business Process Description:*** Colorado's **Manage TPL Recovery** business process is generally aligned with the MITA 3.0 Framework. **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 HCPF will both cost avoid and pay/chase.
Precondition: • Enrolled client • Paid claim • Existence of third party payer
Trigger(s): 1. Identification of any actor or entity who is legally responsible to pay for claim, including cost avoidance.

Manual (M) or Automated (A)	***Steps:***

		Commercial Health Cost Avoidance
1.	M/A	**START**: **Receive** Notification (MS10, CBMS, etc.)
2.	M/A	**Verify** TPL coverage
3.	M	**Enter** TPL information in CBMS
4.	M/A	**Transfer** TPL information to MMIS through interface
5.	A	**END**: MMIS cost **avoids** claim
		Commercial Health Coverage (Pay / Chase)
1.	A	**START**: **Transfer** MMIS eligibility and claim files to TPL Contractor
2.	A	TPL Contractor **performs** data matching of Medicaid eligibility data against commercial health plan eligibility data to determine whether a Medicaid recipient has other coverage
3.	A	If Yes: **Match** claims data with commercial health plan eligibility span
4.	M/A	**Initiate** retraction process with provider (institutional - manual), or **submit** claim to entity for payment (professional – can be EDI or paper)
5.	M/A	If TPL Contractor receives payment, **route** claims adjustment file to MMIS
6.	M/A	For institutional: **send** letter notifying provider of pending retraction with facility
7.	M/A	**Receive** response from institution
8.	M/A	**END**: TPL Contractor **adjusts** claims in MMIS
		Tort & Casualty
1.	M	**START**: **Identification** via potential litigation or claims process
2.	M	**Calculate** amount of medical claims paid by Medicaid related to tort
3.	M	**Assert** Medicaid lien
4.	M	**Ascertain** parties' rights
5.	M	**END**: **Recover** lien
		Medicare Cost Avoidance
1.	M/A	**START:** CBMS **receives** notification of Medicare eligibility
2.	A	**END**: If TPL code indicates Medicare, a. **Transfer** to MMIS through interface b. MMIS **cost avoids** claim

Outcome:

1. Medicaid is payer of last resort
2. Funds recovered
3. Gather information for future claims cost avoidance

As Is Performance Metrics:	***To Be Performance Metrics:***
• Monitor % dollar recovery of overall budget compared to previous year	• Verify and load commercial TPL information within a

• Monitor # of cases for casualty investigations • Verify and load the commercial TPL information into the MMIS within 60 days of the receipt of the referral ***Supporting Performance Metrics/SLA Documentation:*** • Tort – federal and state regulations • C.R.S. § 25.5-4-300.4 • C.R.S. § 25.5-4-301 • 42 USC SEC §§ 401-403, 1381-1383f, 1396b • Deficit Reduction Act of 2005	week of the receipt of the referral
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS 3. CBMS 4. TPL Contractor (e.g. commercial TPL, Medicare, CHAMP VA, DEERS) 5. SSA 6. CMS 7. Railroad Retirement Board 8. Medicare 9. COFRS	***Shared Data/Interfaces, Outbound*:** 1. TPL Contractor (e.g. commercial TPL, Medicare, CHAMP VA, DEERS) 2. MMIS 3. Medicare
To Be Future Vision: 1. Streamline TPL contractor recovery process 2. Improve recovery tracking in MMIS 3. No longer house TPL information in CBMS – place information directly into MMIS (auto or manual). MMIS should own TPL information. 4. Require interface between TPL contractor and MMIS to pipe in validated TPL information 5. Daily TPL processing (currently weekly) 6. BENDEX / SDX / Medicare data in MMIS 7. PARIS (identifies TRI-CARE recipients) data feed / reconciliation process incorporated 8. Verify and load commercial TPL information within a week of the receipt of the referral. 9. Improved picture of true cost avoidance. Nice to know what commercial insurances have paid to understand the true cost avoidance. 10. Once loaded data will be used in real-time processing 11. Automatically capture through a data match, commercial TPL end dates and automatically update the information in the MMIS	
Failures of the Current Process: 1. Data entry errors of the commercial TPL information, death and birth date mistypes, etc. 2. Interface problems (CBMS, MMIS) 3. BENDEX / SDX / Medicare data feeds not in MMIS	

4. Inability to automatically load TPL data 5. Timeliness 6. TRAILS does not send TPL or Medicare data to MMIS 7. Manual interface / Human error 8. Time / Resources 9. Data entry errors resulting in lack of matches (e.g. 'Sally' in Medicaid data, 'Sarah' in Medicare data)
Notes:

Manage Estate Recovery – FM03

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Receivable Management
Business Process: Manage Estate Recovery
Author(s): Cathy Fielder, Diana Lambe, Richard Delaney, John Aldag, Marta Fyffe, Yoseph Daniel, Jocelyn Parkerskel, Jeff Wittreich, Ben Drendel, Sharon Brydon, Ashley Dirienzo, David Smith
Facilitator: Kristin Sparks
Actor(s): Estate Recovery Contractor, Benefits Coordination, Attorneys, Probate Court, AG Office, CDPHE, Peer Review Organization, Facilities, Counties, Client/Family, SSA, CMS (federal)
MITA 3.0 Business Process Description: **Manage Estate Recovery** is a business process that requires States to recover certain Medicaid benefits correctly paid on behalf of an individual, by filing liens against a deceased member's or deceased spouse's estate to recover the costs of Medicaid benefits correctly paid during the time the member was eligible for Medicaid. Estate recovery usually applies to permanently institutionalized individuals such as persons in a nursing facility, Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), or other medical institution. The **Manage Estate Recovery** business process begins by receiving estate recovery information from multiple sources (e.g., vital statistics and Social Security Administration (SSA) date of death matches, probate petition notices, tips from caseworkers, and reports of death from nursing homes). It generates correspondence (e.g., demand of notice to probate court via Send Outbound Transaction, to member's personal representative, generating notice of intent to file claim and exemption questionnaire) via the **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area). In addition, the business process: • Opens a formal estate recovery case based on estate ownership and value of property • Determines the value of the estate lien • Files a petition for a lien • Files an estate claim of lien • Conducts case follow-up • Sends an alert to **Manage Accounts Receivable Information (FM06)** business process (part of the Financial Management business area), releasing the estate lien when recovery is complete • Sends an alert to **Manage Member Information (ME01)** business process (part of the Member Management business area), updating Member data store

Manage Estate Recovery – FM03

NOTE: Do not confuse this with settlements that are recoveries for certain Medicaid benefits correctly paid on behalf of an individual because of a legal ruling or award involving accidents.

CO Business Process Description:
Colorado's **Manage Estate Recovery** business process is generally aligned with the MITA 3.0 Framework. In Colorado, parts of this process are outsourced to an estate recovery contractor. Colorado State Plan provides that HCPF will both cost avoid and pay/chase.

Precondition:
- Age
- Claims paid
- Estate (e.g. property, assets, etc.)

***Trigger(s)*:**
1. Death
2. Institutionalization

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

***Outcome*:**
1. Recover funds

As Is Performance Metrics:	***To Be Performance Metrics:***
• Record and monitor recoveries made and track claims based on percent of recoveries, liens that have been asserted • Probate Law: Estate claim must be filed within 1 year of estate being opened • CMS Guidance: Cannot file liens against MAGI clients • TPL Contractor has a recovery performance metric as	• Increased/improved tracking of LTC demographic data (how long was client on LTC, etc.)

contract requirement • Nursing facilities must update date of death information within 5 days ***Supporting Performance Metrics/SLA Documentation:*** • CRS 25.5-4-302 • 42 USC SEC 1396(p • C.R.S. § 15-12-802(1)(a) • CMS Opinion Letter • Vendor Contract Requirements	
Shared Data/Interfaces, Inbound: 1. CBMS 2. MMIS 3. Social Security 4. CDPHE – Vital Statistics 5. COFRS/CORE 6. DSS 7. Estate Recovery Contractor System 8. Probate court data/records 9. Property records 10. Centers for Medicare & Medicaid Services Buy-In file (supplements BENDEX)	***Shared Data/Interfaces, Outbound*:** 1. Estate Recovery Contractor System 2. MMIS 3. COFRS/CORE
To Be Future Vision: 1. Asset reconciliation with CLEAR (Westlaw) 2. Improved Automation (Date of Death notification) and Tracking (where applicable) 3. Increased/improved LTC demographic data (how long was client on LTC, etc.) 4. Leverage SDX file information in updating death in CBMS	
Failures of the Current Process: 1. Inaccurate or incomplete information 2. Human error – includes counties failing to update CBMS timely 3. No notification of death 4. No definitive date of death. Contractor currently attempts to navigate this by mining data from all sources (SSA, Vital Records).	
Notes:	

Manage Drug Rebate – FM04

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Receivable Management
Business Process: Manage Drug Rebate
Author(s): Cathy Fielder, Diana Lambe, Richard Delaney, John Aldag, Marta Fyfle, Yoseph Daniel, Jocelyn Paskel, Jeff Wittrelan, Ben Drendel, Sharon Brydon, Ashley Dirienzo, David Smith, Vincent Sherry
Facilitator: Kristin Sparks
Actor(s): Drug Rebate Program Staff, Drug Rebate Administrative Management System (DRAMS), Fiscal Agent, CMS, Drug Manufacturers, Providers
MITA 3.0 Business Process Description: The **Manage Drug Rebate** business process describes the process of managing drug rebate that the State Medicaid Agency (SMA) collects from manufacturers. This business process: • Receives quarterly drug rebate information from Centers for Medicare & Medicaid Services (CMS) • Compares drug rebate to quarterly payment history information • Identifies drug information matches based on manufacturer and drug code • Applies the rebate factor and volume indicators • Calculates the total rebate per manufacturer • Prepares drug rebate invoices • Sorts the invoices by manufacturer and drug code • Sends the invoice information to the drug manufacturer via the Send Outbound Transaction • Sends an alert to **Manage Accounts Receivable Information (FM06)** business process (part of the Financial Management business area) to monitor for rebate payment ***CO Business Process Description:*** Colorado's **Manage Drug Rebate** business process is generally aligned with the MITA 3.0 Framework. Colorado has a Quarterly ROA payment due to CMS, based on data in DRAMS.
Precondition: • Rebatable drug • Enrolled clients, eligible for Medicaid • Pharmacy claim is submitted and processed and "travels" from PDCS to DRAMS • Medical claim is submitted and processed and "travels" from MMIS to DRAMS • NDC needs to be on a claim • Supplemental rebates are loaded • Provider must be enrolled as a Medicaid provider

Manage Drug Rebate – FM04

***Trigger(s)*:**
1. Receipt of the CMS quarterly file by fiscal agent

Manual (M) or Automated (A)		***Steps:***
1.	A	**START**: Fiscal Agent **loads** data into DRAMS
2.	M	DRAMS **creates** invoices for manufacturers
3.	M	**END:** DRAMS contractor **sends** hard or soft copy invoices to manufacturers

***Outcome*:**
1. Drug rebate invoices are sent to manufacturers

As Is Performance Metrics:
- N/A

Supporting Performance Metrics/SLA Documentation:
- N/A

To Be Performance Metrics:
- N/A

Shared Data/Interfaces, Inbound:
1. DRAMS
2. PDCS
3. MMIS
4. DSS
5. CMS quarterly file on disk

***Shared Data/Interfaces, Outbound*:**
1. Invoices to manufacturers
2. DRAMS

To Be Future Vision:
1. Improve edit ability in MMIS system to accommodate if NDC is not on claim (Currently available for select procedure codes)
2. Capture all drugs regardless of claims submission type
3. Capture DRAMS data in DSS
4. Determine if CMS quarterly file can be submitted more frequently (and electronically)
5. Maintain table containing all CMS drug rebate files in MMIS and DSS to capture drug rebate history
6. Procedure manual
7. Trained back-up staff
8. Simplify claims tracking processing
9. Obtain managed care organization drug utilization information
10. System tracks and reports physician administered drugs (e.g. “J-Codes”) eligible for drug rebate
11. Indication on claim that the drug is rebate eligible, include rebate % if possible
12. Distinguish 340B claims from non-340B claims

Failures of the Current Process:
1. Takes too long to get data information from fiscal agent

2. All drugs are not being captured regardless of claims submission type (includes DME, physician administered drugs) 3. Quarterly data not received from CMS (or bad disk received, gets lost in mail, delivered elsewhere) 4. Single point of failure – lack of knowledge transfer due to single staff member 5. No feedback/traceability from internal DRAMS claims processing logic 6. Currently not receiving all MCO drug utilization information 7. Historical drug rebate quarterly files not readily available
Notes:

Manage Cost Settlement – FM05

CO MITA 3.0 SS-A Project

Business Area: Financial Management

Business Category: Accounts Receivable Management

Business Process: Manage Cost Settlement

Author(s): Bret Pittenger, Nellie Pon, Cathy Fielder, Eileen Sandoval, Kim Nguyen, Souzan Auran, Sam Seligman, Sharon Brydon, Ashley Dirienzo, Marguerite Richardson, Elizabeth Lopez, Jeremy Tipton, Greg Linster, Matt Haynes

Facilitator: Nicole Wong

Actor(s): Hospitals, Contracted Auditor, Rates and Analysis Staff, Safety Net Staff, Accounting Staff, Intermediaries, Fiscal Agent

MITA 3.0 Business Process Description:

The **Manage Cost Settlement** business process begins with the submission of the provider's annual Medicare Cost Report to Medicaid. Staff makes inquires for paid, denied, and adjusted claims information in the Claims data store. The business process includes:

- Reviewing provider costs and establishing a basis for cost settlements or compliance reviews
- Receiving audited Medicare Cost Report from intermediaries
- Capturing the necessary provider cost settlement information
- Calculating the final annual cost settlement based on the Medicare Cost Report
- Generating the information for notification to the provider
- Verifying the information is correct
- Producing the notifications to providers
- Establishing interim reimbursement rates

NOTE: In some States, the State Medicaid Agency (SMA) may make cost settlements through the **Apply Mass Adjustment (OM05)** business process (part of the Operations Management business area).

CO Business Process Description:

Colorado's **Manage Cost Settlement** business process is generally aligned with the MITA 3.0 Framework. Colorado edited the MITA 3.0 business process description in the following ways:

The **Manage Cost Settlement** business process begins with the submission of the provider's annual audited Medicare Cost Report to Medicaid and contracted auditor. Staff makes inquires for paid, denied, and adjusted claims information in the Claims data store. The business process includes:

- Reviewing provider costs and payments and establishing a basis for cost

- Receiving audited Medicare Cost Report from intermediaries or hospitals
- Compiling the necessary provider cost settlement information: tab runs and audited cost reports
- Calculating the final annual cost settlement based on the audited Medicare and Medicaid Cost Report
- Verifying the tab run information is correct: fiscal agent first then Department staff
- Contracted auditor determines the cost settlement and produces the notifications to providers and Department staff
- The Department submits a financial transaction for payment to providers, processes a check, or establishes an A/R for recoveries

NOTE: In some States, the State Medicaid Agency (SMA) may make cost settlements through the **Apply Mass Adjustment (OM05)** business process (part of the Operations Management business area).

Precondition:

- Outpatient hospital claims are correctly processed
- Audited Medicare Cost Reports are received by the Department's staff/auditor
- Expenditure Summary (TAB RUN) reports are accurate
- Contracted auditor has direct access to the tab run reports
- Interim reimbursement rates are loaded effective every January 1

***Trigger(s)*:**

1. Receipt of the audited Medicare Cost Report

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Contracted Auditor **sends** request for Expenditure Summary Report (TAB RUN) to Rates staff
2.	M	Rates staff **submits** request to Fiscal Agent to create the Expenditure Summary Report (TAB RUN)
3.	M	Fiscal agent **completes** reviews for accuracy, completeness, and corrections for quality control
4.	M	After reviewing tab runs, Rates staff notifies Contracted Auditor of tab run completion and location
5.	M	Contract Auditor **downloads** the tab runs from the location indicated by the Department staff, **conducts** audit, and **determines** settlement amounts
6.	M	Contract Auditor **notifies** Hospital and Rates staff regarding settlement amount; Department staff **submits** the letter of settlement action to the provider
7.	M	Hospital **files** an appeal within 30 days, if desired (see **Manage Provider Grievance and Appeal (PM07)** business process (part of the Provider

		Management business area))
8.	M/A	**END: Process** payment/recovery. The hospital sends a check or the Department processes an account receivable (A/R) for recovery or a financial transaction for payment

Outcome:
1. Payments are reconciled to bring expenditures in line with the targeted percent of cost

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Time to complete – Need a measure in future if it doesn't exist today
Shared Data/Interfaces, Inbound: 1. MMIS 2. COLD 3. DSS 4. COFRS/CORE 5. Hospitals 6. Contract Auditor 7. Intermediaries	***Shared Data/Interfaces, Outbound***: 1. MMIS 2. COLD 3. DSS 4. COFRS/CORE 5. Hospitals 6. Contract Auditor

To Be Future Vision:
1. Ensure validation of Expenditure Summary Report (TAB RUN) output
2. MMIS supports prospective payments to avoid cost settlement
3. Flexible reporting capabilities:
   a. Does not fail if a value is too large
   b. Flexibility on updating/correcting summary reports
   c. Rates staff has access to the reporting they need without the Fiscal Agent;
   d. Ability to see information at a high-level, or drill down to details as desired;
   e. Rates staff has the ability to access coding for the creation of the reports.
   f. Documentation of data included/excluded in the creation of the reports as well as the data sources used in the creation of the reports (detail data fields and table source)
4. Configurable system that reduces or eliminates the need for Change Systems Requests (CSRs)

Failures of the Current Process:
1. Delay in CMS decision delays cost reporting from hospitals and intermediaries
2. Expenditure Summary Report (TAB RUN) does not always calculate correctly; large values and missing data can cause calculation errors in the report
3. Limited validation of Expenditure Summary Report (TAB RUN) output
4. Outdated or inaccurate information due to program/policy changes not included in the

creation of the tab run reports 5. Errors in the data input used for the creation of the summary report (tab runs)
Notes:

Manage Accounts Receivable Information – FM06

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Receivable Management
Business Process: Manage Accounts Receivable Information
Author(s): Bret Pittenger, Nellie Pon, Cathy Fielder, Eileen Sandoval, Kim Nguyen, Souzan Auran, Sam Seligman, Sharon Brydon, Ashley Dirienzo, Greg Tanner
Facilitator: Nicole Wong
Actor(s): Recovery Contractors, Accounting, Audits, Program Integrity, Benefits Coordination, Providers, CMS, Attorney General's Office, CDPHE, MFCU, DHS, Counties, OAC, State Collections, Attorneys, Local, State, Federal Courts
MITA 3.0 Business Process Description: The **Manage Accounts Receivable Information** business process is responsible for all operational aspects of collecting money owed to the State Medicaid Agency (SMA). Activities in this business process comply with CFR 45, Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). Activities included in this business process can be as follows: • Periodic reconciliations between the State Medicaid Enterprise and the state accounting system • Assign account coding to transactions processed in State Medicaid Enterprise • Process accounts receivable invoicing (estate recovery, co-pay, drug rebate, recoupment, Third-Party Liability (TPL) recovery, and member premiums) • Manage cash receipting process • Manage payment-offset process to collect receivables • Respond to inquiries concerning accounts receivable **NOTE**: States use a variety of solutions including outsourcing to another department or use of a Commercial Off-the-Shelf (COTS) package. ***CO Business Process Description:*** Colorado's **Manage Accounts Receivable Information** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • **Manage Cost Settlement (FM05)** business process (part of the Financial Management business area)

- **Manage Drug Rebate (FM04)** business process (part of the Financial Management business area)
- **Manage TPL Recovery (FM02)** business process (part of the Financial Management business area)
- **Manage Estate Recovery (FM03)** business process (part of the Financial Management business area)
- **Manage Provider Recoupment (FM01)** business process (part of the Financial Management business area)

***Trigger(s)*:**

1. Receive initial notification of accounts receivable from **Manage Provider Recoupment (FM01)**, **Manage TPL Recovery (FM02), Manage Estate Recovery (FM03)**, **Manage Drug Rebate (FM04)**, or **Manage Cost Settlement (FM05)** business processes (part of the Financial Management business area)
2. Receive account receivable information from state accounting system, State Collections, IRS, Audits, and MMIS. This may be a lien, levy or state judgment from other agencies.

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** initial accounts receivable notification to establish the receivable amount and demographic information for the debt owner
2.	M/A	**Record** accounts receivable payments to the account balance
3.	M/A	**Adjust** balance for additional accounts receivable amounts. An adjustment may increase or decrease the balance. a. The adjustments include settlements, liens, levies, and/or judgments against the accounts receivable b. The SMA may receive the adjustment from **Manage Provider Recoupment (FM01)**, **Manage TPL Recovery (FM02)**, **Manage Estate Recovery (FM03)**, **Manage Drug Rebate (FM04)**, or **Manage Cost Settlement (FM05)** business processes (part of the Financial Management business area) or **Manage Provider Grievance and Appeals (PM07)** business process (part of Provider Management business area) or other State or federal agencies
4.	M/A	**Update** the state accounting system
5.	M/A	**END: Track** collection of payment via the **Manage Accounts Receivable Funds (FM07)** business process (part of the Financial Management business area)

***Outcome*:**

1. The SMA modifies account receivables information
2. Trigger **Manage Accounts Receivable Funds (FM07)** business process (part of the

Financial Management business area) 3. Tracking information as needed for measuring performance and business activity monitoring	
As Is Performance Metrics: Program Integrity/Audits: • Within 30 days of date of demand letter, contact Office of Administrative Court to see if the provider has filed an appeal. If the provider has not filed an appeal they are set up for 100% offset. • Within 45 days of date of demand letter, respond to provider on backup documents sent in by provider. Informal reconsideration letter becomes the new demand letter. • In between the first demand letter and the informal reconsideration, the provider has the right to file an appeal or pay in full or setup a payment plan • Within 90 days of date of demand letter, if we haven't heard from the provider, State has the right to setup accounts receivable for 100% Tort/Casualty • Monitoring how much is written off in attorney fees on a quarterly basis. Goal is zero ***Supporting Performance Metrics/SLA Documentation:*** • Colorado Statutes (2009): 25.5-4-301 • 10 CCR 2505-10 8.050.6.C	***To Be Performance Metrics:*** • Same as As-Is • Set up accounts receivables within 3 business days of notification to accounting
Shared Data/Interfaces, Inbound: 1. COFRS/CORE 2. MMIS 3. Recovery Contractors 4. Access databases and Excel spreadsheets 5. COLD 6. State Collections 7. MFCU 8. Other State agencies (e.g. AG)	***Shared Data/Interfaces, Outbound*:** 1. COFRS/CORE 2. MMIS 3. Recovery Contractors 4. COLD 5. Access databases and Excel spreadsheets 6. Interagency Monthly Report
To Be Future Vision:	

Manage Accounts Receivable Information – FM06

1. Reports that identify which accounts receivables are created broken down by agency division 2. Setup account receivable within 3 business days of notification to accounting 3. Financial system (COFRS/CORE) passes accounts receivables data directly (bi-directional) to the MMIS
Failures of the Current Process: 1. Unable to distinguish agency division owner of the accounts receivables 2. The MMIS financial system shows a payment has posted when it actually hasn't occurred yet so the current balance isn't accurately reflected 3. Lack of bi-directional communication between the MMIS and COFRS/CORE (state financial system)
Notes:

Manage Accounts Receivable Funds – FM07

CO MITA 3.0 SS-A Project

Business Area: Financial Management

Business Category: Accounts Receivable Management

Business Process: Manage Accounts Receivable Funds

Author(s): Cathy Fielder, Jackie Henderson, Sado Tesfaye, Souzan Auran, Diana Lambe, Tim Gaub, Eileen Sandoval, Ben Drendel, Erick Croy

Facilitator: Kristin Sparks

Actor(s): Accounting, RAC and Contingency Contractor, Fiscal Agent, Payees, Audits, Other State Agencies, State Collections, Attorney General, Courts, MFCU, National MFCU, Treasury

MITA 3.0 Business Process Description:
The **Manage Accounts Receivable Funds** business process is responsible for all operations aspects of the collection of payment owed to the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Improvement Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP).

CO Business Process Description:
Colorado's **Manage Accounts Receivable Funds** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- **Manage Accounts Receivable Information (FM06)** business process (part of the Financial Management business area)

Trigger(s):
1. Receive payment (e.g., cash, check, lockbox)
2. Receive electronic payment (e.g., electronic funds transfer or interagency transfers (ITs)

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** payment (e.g., cash, check, ITs, electronic funds transfer)
2.	M/A	**Record** the payer and payment amount information
3.	M/A	**END: Apply** payment to accounts receivable and continue tracking the accounts receivable. If paid in full, close account

Outcome:
1. The State Medicaid Agency (SMA) receives payment and applies to accounts receivable
2. Tracking accounts receivables as needed for measuring performance and business activity monitoring

Manage Accounts Receivable Funds – FM07

As Is Performance Metrics:	***To Be Performance Metrics:***
• Checks must be deposited in the same month that they are received. If a check is received on the last day of the month, it must be deposited by 2:00 PM on that day. • Cash must be deposited within 24 hours, with some exceptions ***Supporting Performance Metrics/SLA Documentation:*** • 24-36-103, C.R.S (Transmit Monies to State Treasurer Rule 6-1 • Governmental Accounting Standards Board (GASB) • Generally Accepted Accounting Principles (GAAP)	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. COFRS/CORE 2. Accounts Receivable Access Database 3. MMIS 4. COLD 5. Recovery Audit Contractor (RAC) and Contingency Contractor data store 6. CBMS 7. LTSS Demand Summary Excel Spreadsheet	***Shared Data/Interfaces, Outbound*:** 1. COFRS/CORE 2. COLD 3. Division tracking Excel spreadsheets and/or databases 4. Governor's Report
To Be Future Vision: 1. Accept debit/credit card payments and eventually eliminate the use of checks 2. Set up accounts receivable within three business days 3. Automate the manual check deposit slip 4. Implement check scanning application (similar to ATM at bank or a retail scanner) 5. MMIS Training (This may be added in more general sense as well.) 6. Be able to view the provider agreement from the MMIS. (Currently in DocFinity) 7. Reports that identify which accounts receivables are created, broken down by agency division 8. Unable to distinguish agency division owner of the accounts receivables	
Failures of the Current Process: 1. Unable to distinguish agency division owner of the accounts receivables 2. The MMIS financial system shows a payment has posted when it actually hasn't occurred yet so the current balance isn't accurately reflected 3. Lack of bi-directional communication between the MMIS and COFRS/CORE (state	

financial system)
Notes:

Prepare Member Premium Invoice – FM08

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Receivable Management
Business Process: Prepare Member Premium Invoice
Author(s): Cathy Fielder, Jackie Henderson, Sado Tesfaye, Souzan Auran, Diana Lambe, Tim Gaub, Eileen Sandoval, Ben Drendel, Martha Beavers, Cheryl Nelson
Facilitator: Kristin Sparks
Actor(s): Clients, CHP+ Staff, Accounting Staff, Medicaid Buy-In and CHP+ Contractor, Medicaid Buy-In staff, Banks, Treasury,
MITA 3.0 Business Process Description: States may implement member cost sharing through the collection of premiums for medical coverage provided under Medicaid and Children's Health Insurance Program (CHIP). The State Medicaid Agency (SMA) formulates the premium amounts on factors such as family size, income, age, benefit plan, and in some cases the selected health plan, if covered under managed care, during eligibility determination and enrollment. The **Prepare Member Premium Invoice** business process begins with a timetable (usually monthly) for scheduled invoicing. The business process includes: • Retrieving member premium information. • Performing required information manipulation according to business rules. • Formatting the results into required output information. • Sending member premium invoice alert to the **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area). **NOTE**: This business process does not include sending the member premium invoice Electronic Data Interchange (EDI) transaction. ***CO Business Process Description:*** Colorado's **Prepare Member Premium Invoice** business process is generally aligned with the MITA 3.0 Framework. Colorado implements client cost sharing through the collection of premiums for medical coverage provided under the Medicaid/SCHIP umbrella. This program is called CHP+ at Work and Medicaid Buy-In (or Disabled Buy-In).
Precondition: • Eligible for CHP+

- Disabled and eligible for Medicaid Buy-In

***Trigger(s)*:**
1. Client completes Medicaid/CHP+ application and submits to HCPF

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** application
2.	M/A	Eligibility site **review** application for completeness and required documentation
3.	M	**Contact** applicant if additional documentation is needed
4.	M/A	**Enter** application information in CBMS
5.	A	**Determine** eligibility using logic within CBMS
6.	A	CBMS **generates** and **sends** letter of approval/denial indicating that a premium may be due
7.	M/A	• Interface file **processes** into CBMS to update premium paid • Walk in or exception payments are **processed** by contractor directly into CBMS • If Accounting receives manual checks they **forward** to contractor for processing into CBMS • Funds are **transferred** from Lockbox account to Provider fee case fund on a regular basis • There is no reconciliation between payments posted within CBMS vs. money received.
8.	M	**Review** the bank statements and **reconcile**
9.	M	**END**: Accounting **processes** client premium payment

***Outcome*:**
1. Premium invoice is prepared
2. Received premiums are recorded
3. Client premiums are reimbursed or following month is credited for clients who have overpaid

As Is Performance Metrics:	***To Be Performance Metrics:***
• Contractual requirements for Medicaid Buy-In and CHP+ contractor to prepare and send invoices to clients ***Supporting Performance Metrics/SLA Documentation:*** • SLAs	• Reduce the number of premium reimbursements for denial

Prepare Member Premium Invoice – FM08

Shared Data/Interfaces, Inbound:	***Shared Data/Interfaces, Outbound:***
1. CBMS 2. COFRS/CORE 3. Reports/statements for Accounting 4. Medicaid Buy-In and CHP+ Contractor 5. Financial Data Warehouse 6. Online banking system	1. COFRS/CORE
To Be Future Vision: 1. Integrate the program with existing systems (CBMS or MMIS) 2. Flexible MMIS, with ability to add new programs as needed 3. Automate – reduce paper 4. Online submission of applications 5. Eligibility should be the trigger for decision to invoice. 6. Some clients claim that they have paid premiums, but Medicaid Buy-In and CHP+ Contractor indicates that the client has not paid. Accounting must manually go in and verify. Need process to reconcile that payment received to bank for XX client was processed to CBMS for XX client in same amount.	
Failures of the Current Process: 1. No tracking of funds received offset amounts posted into system 2. Responsibility is on client to show proof of payment 3. Process is all manual 4. Program processing can't be added into CBMS 5. Clients don't always display on report and checks don't get issued 6. Insufficient database (Access) 7. Only a couple of established reports built into the Access database; other data requests must be made through Claims System Support (CSS) 8. Delay in eligibility determination resulting in premium reimbursements to denied clients	
Notes:	

Manage Contractor Payment–FM09

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Payable Management
Business Process: Manage Contractor Payment
Author(s): Marta Fyffe, Sharon Brydon, Ben Drendel, David Smith
Other Attendance (non-participating): Mark Shaffer
Facilitator: Kristin Sparks
Actor(s): Procurement, Contractors, Program Manager, Accounts Payable Accountant, Authorized Approver in Accounting
MITA 3.0 Business Process Description: The **Manage Contractor Payment** business process includes the activities necessary to reimburse contractors for services rendered based on a contract executed between the State Medicaid Agency (SMA) and the contractor. When a contractor renders services on behalf of a Medicaid member, the contractor invoices Medicaid according to the specifics defined in the contract. Agency staff responsible for the Contract Administration process invoices according to the SMA policy, including validation of the invoice content to reimbursement details defined in the contract. ***CO Business Process Description:*** Colorado's **Manage Contractor Payment** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Existing contract • Contractor rendered services • Encumbrance in place
Trigger(s): 1. Receive invoice from contractor (i.e., email, mail, facsimile)

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** invoice from contractor
2.	M	**Validate** invoice details for reimbursement details defined in the contract
3.	M	**Resolve** any invoicing discrepancies discovered with contractor
4.	M	**END**: **Trigger Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area) to generate contractor payment

Manage Contractor Payment–FM09

<table>
<tr><td colspan="2">Outcome:
1. Trigger Manage Accounts Payable Information (FM13) business process (part of the Financial Management business area) to generate contractor payment
2. Tracking information as needed for measuring performance and business activity monitoring
3. Trigger the Prepare Provider Payment (OM27) business process (part of the Operations Management business area)</td></tr>
<tr><td>As Is Performance Metrics:
• N/A

Supporting Performance Metrics/SLA Documentation:
• GAAP
• GASB
• CISM</td><td>To Be Performance Metrics:
• Include requirements for timely processing and payment in the Contract</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. COFRS/CORE System
2. Recovery Audit Contractor (RAC) recovery information
3. MMIS
4. Contract information</td><td>Shared Data/Interfaces, Outbound:
1. COFRS/CORE System
2. COLD Reports
3. Financial Data Warehouse
4. MMIS
5. Document Direct</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. Receive electronic invoice from contractor (i.e., Electronic Data Interchange (EDI))
2. Removing all paper transactions from the process</td></tr>
<tr><td colspan="2">Failures of the Current Process:
1. Invoice does not match existing contractor information</td></tr>
<tr><td colspan="2">Notes:</td></tr>
</table>

Manage Member Financial Participation – FM10

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Payable Management
Business Process: Manage Member Financial Participation
Author(s): Marta Fyffe, Sharon Brydon, Ben Drendel, David Smith
Other Attendance (non-participating): Mark Shaffer
Facilitator: Kristin Sparks
Actor(s): Health Insurance Buy-in Officer (HIBI), Fiscal Agent, Client or Advocate, County Department of Human Services, Third Party Insurers, CMS, SSA, RRB, Civil Service, Other State Medicare Buy-in Contacts, Other State Eligibility Workers, Financial Institutions
MITA 3.0 Business Process Description: The **Manage Member Financial Participation** business process is responsible for all operations aspects of preparing member premium payments. This includes premiums for Medicare, also known as Medicare Buy-in, and other health insurance. The business process begins with the alert to determine if the State Medicaid Agency (SMA) should pay a member's premium. The SMA will assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a process referred to as buy- in. Under the buy-in process the SMA, the Social Security Administration (SSA), and U.S. Department of Health & Human Services (HHS) enter into a contract where States pay the Medicare beneficiary share of premium costs, and, in some instances, deductibles, and co-insurance. An exchange of eligibility information between Medicare and the SMA initiates Medicare premium payments. The service agreement between the SMA and business partner determines the intervals for this business process to execute. The business process receives eligibility information from Medicare, performs a matching process against the State Medicaid Enterprise member data store, generates buy-in files to Centers for Medicare & Medicaid Services (CMS) for verification, receives premium payment information from and generates payments to CMS. The SMA will pay the private health insurance premiums for members who have private health insurance benefits if it determines the insurance to be cost effective. In these circumstances, the SMA prepares and sends a premium to the member's private health insurance company. Health insurance premium payments initiate with an application for Medicaid where the

applicant indicates that they have third-party health coverage, or by receiving eligibility information via referrals from Home and Community-Based Services (HCBS) Offices, schools, community services organizations, or phone calls directly from clients. The business process checks for internal eligibility status as well as eligibility with other payers, producing a report identifying individuals where paying premiums would be cost effective, and notifying members via **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area).

NOTE: This business process does not include sending the premium payments as an Electronic Data Interchange (EDI) transaction.

CO Business Process Description:

Colorado's **Manage Member Financial Participation** business process is generally aligned with the MITA 3.0 Framework, but the Department does get involved in ensuring that the client gets the appropriate Medicare premium refund(s). They work with Federal agencies to resolve any discrepancies. In regards to the HIBI Program, the State can pay the premium to any type of entity and is not constrained to the insurance company (e.g., client, employer, policy holder, etc.). The State has delegated the HIBI program operations to a contractor. HIBI referrals are also received from a website.

***Precondition*:**

HIBI

- Client has to be eligible for Medicaid
- Client must have access to commercial health coverage
- The case must be cost effective

Medicare Buy-in

- Client eligibility, demographic, and Medicare data must be contained in the MMIS and match CMS data
- Client is enrolled in Medicaid or Medicare Savings Program (MSP)
- State has active Medicare Buy-in agreement with CMS

***Trigger(s)*:**

HIBI

1. Application is received and approved
2. Premium payments and administrative fees are paid (monthly)

Medicare Buy-in

1. Client has either Medicaid or MSP and has Medicare
2. The Medicare Buy-in accretion program and/or termination program runs

Manual (M) or Automated (A)		***Steps:***
HIBI		
		Initial Sequence

1.	M/A	**START**: **Verify** that regular HIBI amount is correct
2.	A	**Calculate** HIBI amount for that month (if different than auto payment)
3.	M/A	**END**: HIBI contractor **sets up** initial payment
		Ongoing Sequence
1.	M/A	**START: Capture** and **analyze** plan and/or rate changes
2.	M/A	**Verify** current TPL information and **update** as necessary
3.	M/A	**Verify** employee's contribution or premium payment and **calculate** amount of premium assistance
4.	M/A	**Verify** Information contained in the HIBI contractor's system for accuracy
5.	M/A	**Reconcile** any discrepancies or barriers to distributing payment to client
6.	A	**Run** final report
7.	M/A	**Setup** the EFT transaction between the accounting department and the HIBI contractor
8.	M/A	**END**: Client **receives** premium payment in their bank account
Medicare Buy-in		
1.	A	**Start:** State Medicare Buy-in system (currently MMIS) **receives** data in client eligibility file from eligibility system (currently CBMS) indicating client accretion (add), deletion or change transactions
2.	A	**Create** weekly buy-in file, according to schedule
3.	A	**Submit** buy-in file to CMS, according to schedule
4.	A	CMS **processes** and **responds** to State requests and includes CMS identified client record updates
5.	A	State **receives** CMS responses daily
6.	A	State **receives** monthly billing file from CMS, which includes the premium amounts to be paid
7.	A	State **validates** data and posts transactions to MMIS.
8.	M	Medicare Buy-in Officer **researches** the rejects from CMS and works with various entities (e.g., County Workers, CMS, SSA, etc.) to resolve the issue and take appropriate action
9.	M	Medicare Buy-in Officer **retrieves** COLD report based on MMIS data to prepare Medicare premium payment
10.	M	Medicare Buy-in Officer **verifies** amounts in COLD reports are balanced to invoice
11.	M	Medicare Buy-in Officer **sends** supporting documentation to accounting
12.	M	Accounting **verifies** supporting documentation
13.	M	**End:** Accounting **creates** payment in the statewide accounting system

Manage Member Financial Participation – FM10

Outcome:

HIBI

1. Premium payment remitted to contractor

Medicare Buy-in

1. Medicare Buy-in is started or stopped accurately and CMS is paid for the Medicare beneficiary share of premium costs

As Is Performance Metrics:	***To Be Performance Metrics:***

HIBI
1. Review reporting to determine if HIBI contractor is making accurate application determinations
2. Payment amounts are correct
3. Measure the number of clients enrolled in the program (statutory cap of 2000 enrollees)
 	
Medicare Buy-in
1. Premiums are paid accurately (i.e., the billing file and reports and paper invoice from CMS reconcile)
2. FFP is allocated correctly
3. Buy-in is accreted and deleted accurately and timely
4. Monitor client count and dollars spent
 	
Supporting Performance Metrics/SLA Documentation:
• HIBI Contractor Contract
• CFR, SSA, Revised Statutes
  o SEC 1818, 42 U.S.C. 1395i-2, Part A for Uninsured Elderly
  o SEC 1843, 42 U.S.C. 1395v, State Agreements
  o SEC 1844, 42 U.S.C. 1395w, Government Contributions
  o SEC 1836, 42 U.S.C. 1395O, eligible Individuals
  o SEC 1839, 42 U.S.C. 1395r, Amounts of Premiums
  o SEC 1837, 42 U.S.C. 1395p, Enrollment Periods
  o SEC 1842, 42 U.S.C. 1395u, Use of Carriers for Administration of Benefits
  o SEC 1902, 42 U.S.C. 1396a, State Plans for Medical Assistance
  o SEC 1905, 42 U.S.C. 1396d, Definitions
  o 42 CFR §431.625, Coordination of Medicaid
	HIBI
	1. Achieve the statutory enrollment cap
	2. Increase cost savings numbers
	Medicare Buy-in
	1. Same as As-Is

with Medicare Part B o Social Security Act Title 18, Health Insurance for the Aged & Disabled o STATE MEDICAID MANUAL o Medicare Buy-In Agreements 1966-1985 o C.R.S. 25.5-5-104, Qualified Medicare Beneficiaries o C.R.S. 25.5-5-105, Qualified Disabled and Working Individuals o C.R.S. 26-4-1204(5), Medicaid Buy-In-Eligibility—Premiums-Medicare (obsolete) o Volume 8: 8.062, 8.111, 8.121, 8.122, 8.123	
Shared Data/Interfaces, Inbound: 1. MMIS 2. CBMS 3. COFRS/CORE 4. CMS (applies to Medicaid Buy-in) 5. OIT (state mainframe) (applies to Medicaid Buy-in) 6. Commercial insurance carrier eligibility portals	***Shared Data/Interfaces, Outbound*:** 1. COFRS/CORE 2. MMIS 3. CBMS 4. DSS 5. COLD 6. CMS 7. OIT (state mainframe)
To Be Future Vision: 1. Enhanced reporting 2. Improve automation of Medicare verification process 3. Automate Medicare payment through MMIS 4. Create a direct interface from MMIS to CMS (bi-directional) 5. Increased flexibility to audit and manage logic 6. Receive most recent application date from CBMS on an interface directly with MMIS 7. Enhanced ability to track clients that move in and out of the state (and its impact on Medicare buy-in eligibility) 8. Ability for MMIS to receive BENDEX file or receive Medicare information 9. Provide electronic report access to counties 10. Ability to create ad hoc reports 11. Ability to archive historical billing file 12. Ability to easily configure processing and reporting frequency 13. Configurable values	
Failures of the Current Process: 1. Data entry errors in HIBI contractor system 2. Time and resources	

3. Manual processing and workarounds 4. Medicare Buy-in process Human error 5. Inaccurate data from CMS or CBMS 6. Eligibility span issues 7. CMS Medicare Buy-in summary statement not received 8. 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 9. Billing file is overwritten with each cycle; losing audit history for Medicare Buy-in 10. CBMS data entry errors or inconsistencies resulting in MMIS/CMS mismatches (e.g. entering “Sally” rather than “Sarah”)
Notes:

Manage Capitation Payment–FM11

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Payable Management
Business Process: Manage Capitation Payment
Author(s): Marta Fyffe, Vicki Foreman, Jerry Smallwood, Greg Tanner
Facilitator: Kristin Sparks
Actor(s): MCOs, PCCMs, PIHPs, Clients, Department Staff
MITA 3.0 Business Process Description: The **Manage Capitation Payment** business process includes the activities to prepare Primary Care Case Management (PCCM) or Managed Care Organization (MCO) capitation payments. Some States offer members the option of enrolling in a PCCM product that requires the selection of a Primary Care Physician (PCP). The PCP receives a Per-Member-Per-Month (PMPM) capitation payment amount for all members that the State Medicaid Agency (SMA) assigns. The provider payment schedule defines the PCCM capitation rates typically actuary based on an age and gender rating or flat rate. Provider may opt in or out of PCCM plan and does not have to belong to the MCO. A prevailing alternative to the SMA integrated managed care model is to delegate specific member populations to MCOs and pay the MCO a PMPM capitation amount for all assigned members. The **Manage Capitation Payment** business process integrates the member, provider, and MCO, member assignment and contract capitation information, and creates the information extract necessary to generate the capitation payment. The data extract includes any processing rules and options including retroactive adjustments to member assignments that affect the capitation payment amount to the provider or MCO. ***CO Business Process Description:*** Colorado's **Manage Capitation Payment** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Client must be eligible for Medicaid and enrolled in the PCCM, PIHP, or an MCO • Provider enrolled with PCCM, PIHP, or MCO • Provider must be enrolled in Medicaid program
Trigger(s): 1. Monthly capitation run 2. Client enrollment

Manage Capitation Payment–FM11

Manual (M) or Automated (A)		***Steps:***
1.	A	**START**: Capitation **run** on the first Saturday of the month
2.	A	**END**: **Trigger Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area) to **generate** provider/MCO capitation payments

Outcome:

1. Trigger **Manage Accounts Payable Information (FM13)** business process (part of Financial Management business area) to generate Provider/MCO capitation payments
2. Tracking information as needed for measuring performance and business activity monitoring

As Is Performance Metrics:	***To Be Performance Metrics:***
• Providers are paid on a monthly basis ***Supporting Performance Metrics/SLA Documentation:*** • Contracts with MCOs, PCCMs, PIHPs	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. COFRS/CORE 2. MMIS 3. CBMS	***Shared Data/Interfaces, Outbound***: 1. COFRS/CORE 2. COLD reports to MCOs, PCCMs, PIHPs 3. Capitation reports to MCOs, PCCMs, PIHPs 4. Monthly summary reports to MCOs, PCCMs, PIHPs 5. MMIS 6. Provider Portal

To Be Future Vision:

1. Be able to export and manipulate data to support analysis of the program
2. Expand on reports with additional fields
3. Use 834 transaction to communicate enrollments, disenrollments, and other changes to the MCOs, PCCMs, PIHPs

Failures of the Current Process:

1. Reports limited in byte size
2. Unable to export reports (no manipulation possible, static)
3. Failure #2 leads to misinterpretation of data between program and policy staff and providers

Manage Capitation Payment–FM11

Notes:

Manage Incentive Payment–FM12

CO MITA 3.0 SS-A Project

Business Area: Financial Management	
Business Category: Accounts Payable Management	
Business Process: Manage Incentive Payment	
Author(s): Marta Fyffe, Vicki Foreman, Jerry Smallwood, Sado Tesfaye, Amelia Larsen, Kathryn Jantz, Tim Gaub, Greg Tanner	
Facilitator: Kristin Sparks	
Actor(s): Providers, CMS, Fiscal Agent, Department Staff	
MITA 3.0 Business Process Description: The **Manage Incentive Payment** business process accommodates administration of various incentive compensations to payers, providers, and members. Federal or state policy defines the programs, which are typically short duration and limited in scope. The policy defines specific periods, qualification criteria, and certification or verification requirements. The **Manage Incentive Payment** business process follows the **Maintain Program Policy (PL02)** business process (part of Plan Management business area) that manages program administrative rules, whether federal or state, and concludes with paying the payer, provider, or member. ***CO Business Process Description:*** Colorado's **Manage Incentive Payment** business process is generally aligned with the MITA 3.0 Framework. Specifically, in Colorado, incentive programs include the Provider Electronic Health Record and Quarterly Accountable Care Collaborative (ACC) Incentive payments.	
Precondition: • Providers must be enrolled in the Medicaid program as active providers • EHR: Providers must meet CMS attestation criteria • Quarterly ACC Incentive Payment: Performance standards applied based on ACC-enrolled clients seen by the provider over a specific period of time • **Maintain Program Policy (PL02)** business process (part of the Plan Management business area)	
Trigger(s): 1. Receive addition or modification of incentive program based on federal or state policy. 2. Quarterly ACC Incentive Payment: Quarterly measurement of performance. 3. EHR: CMS attestation process.	
Manual (M) or Automated (A)	***Steps:***

1.	M/A	**START**: **Receive** addition or modification of incentive program based on federal or state policy
2.	M/A	The State Medicaid Agency (SMA) **disseminates** federal or state policy regarding incentive program
3.	M/A	Payer, provider, or client **applies** for incentive
4.	M	State **determines** if payer, provider, or client is eligible for incentive program
5.	M	Payer, provider, or client **performs** activities defined in incentive program policy
6.	M	EHR only: Payer, provider, or client **submits** artifacts required for compliance
7.	M	EHR only: Payer, provider, or client **requests** payment
8.	M	State **determines** appropriate payment based on policy guidelines
9.	M	**END**: **Trigger Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area) to generate payment to payer, provider, or client

Outcome:

1. Trigger **Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area) to generate payer, provider or member payment
2. Quarterly ACC Incentive: Develop financial transaction document, which is sent to the fiscal agent
3. EHR: Report sent to fiscal agent, and fiscal agent generates payment
4. Tracking information as needed for measuring performance and business activity monitoring

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. Centers for Medicare & Medicaid Services (CMS) Health Information Technology for Economic and Clinical Health (HITECH) Provider Electronic Health Record (EHR) Incentive Program Registration and Attestation (R&A) System 2. COFRS/CORE 3. MMIS 4. CBMS	***Shared Data/Interfaces, Outbound***: 1. Centers for Medicare & Medicaid Services (CMS) Health Information Technology for Economic and Clinical Health (HITECH) Provider Electronic Health Record (EHR) Incentive

5. SDAC	Program Registration and Attestation (R&A) System 2. Managed care reports 820 and 835 (ACC) 3. 835 to providers for HER 4. COFRS/CORE 5. MMIS 6. Spreadsheets 7. SDAC
To Be Future Vision: 1. Automated exchange of information with CMS	
Failures of the Current Process: 1. Payer, provider, or member is not eligible for incentive program 2. Payer, provider, or member does not perform activities defined in incentive program policy 3. Payer, provider, or member does not submit artifacts required for compliance	
Notes:	

Manage Accounts Payable Information– FM13

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Payable Management
Business Process: Manage Accounts Payable Information
Author(s): Marta Fyffe, Sandy Salus, Clark Akins, Ben Drendel, Bret Pittenger, Greg Tanner
Facilitator: Nicole Wong
Actor(s): Providers, Contractors, Fiscal Agent, Department Staff

MITA 3.0 Business Process Description:

The **Manage Accounts Payable Information** business process is responsible for all operational aspects of money the State Medicaid Agency (SMA) pays. Activities in this business process comply with Cash Management Act, Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP).

Activities included in this process may be:

- Periodic reconciliations between the State Medicaid Enterprise and the system(s) that performs accounting functions
- Assignment of account coding to transactions processed in the State Medicaid Enterprise
- Processing accounts payable invoices created in the State Medicaid Enterprise
- Processing accounts payable invoices created in state accounting system (gross adjustments or other service payments not processed through the State Medicaid Enterprise, and administrative payables)
- Loading accounts payable information (warrant number, date, etc.) into the State Medicaid Enterprise
- Managing canceled/voided/stale dated warrants
- Performing payroll activities
- Disbursing federal administrative costs reimbursements to other entities
- Responding to inquiries concerning accounting activities

NOTE: States use a variety of solutions including outsourcing to another department or use of a Commercial-Off-the-Shelf (COTS) package.

CO Business Process Description:

Colorado's **Manage Accounts Payable Information** business process is generally aligned with the MITA 3.0 Framework. The only notable difference is the only reconciliation that

occurs is when accounting receives a receipting report or encumbrance, accounting looks at the receiving report and encumbrances to make sure it balances.

Precondition:

- Encumbrance
- **Manage Contractor Payment (FM09)** business process (part of the Financial Management business area)
- **Manage Incentive Payment (FM12)** business process (part of the Financial Management business area)
- **Manage Member Financial Participation (FM10)** business process (part of the Financial Management business area)
- **Manage 1099 (FM15)** business process (part of the Financial Management business area) - W-9 to set up the contractor in our system
- **Manage Capitation Payment (FM11)** business process (part of the Financial Management business area)

***Trigger(s)*:**

1. Financial Transaction Transmittal
2. Invoice from contractor
3. Receiving report from program
4. Provider would submit a claim
5. Other requests for payment
6. Receive accounts payable information

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** request and information to make payment
2.	M/A	**Perform** requested function
3.	A	**Produce** COLD reports
4.	M/A	**Produce** financial transaction
5.	A	**Update** financial information in COFRS/CORE
6.	M/A	**END:** Trigger **Manage Accounts Payable Disbursement (FM14)** business process (part of the Financial Management business area)

***Outcome*:**

1. Modification to accounts payable information
2. Trigger **Manage Accounts Payable Disbursement (FM14)** business process (part of the Financial Management business area)
3. Tracking information as needed for measuring performance and business activity monitoring

As Is Performance Metrics:	***To Be Performance Metrics:***
• Payment has to be available to provider 3 business	• Tracking of days elapsed

days prior to the payment date or 3 business days after the payment date for 90% of claims. To be compliant with the Core Operating Rule. ***Supporting Performance Metrics/SLA Documentation:*** • Federal Rule 370 – Core Operating Rule • State Medicaid Manual • GASB, GAAP, CMIA	between Date of Service and Date Paid • Same as As-Is
Shared Data/Interfaces, Inbound: 1. COFRS/CORE 2. Colorado Payroll and Personnel System (CPPS) 3. MMIS	***Shared Data/Interfaces, Outbound*:** 1. COFRS/CORE 2. CPPS 3. Financial Data Warehouse (FDW) 4. HR DW 5. Document Direct (static reporting tool) 6. DW/DSS 7. MMIS 8. Employee Self-Service (ESS)
To Be Future Vision: 1. Vendors are going to be required to register in the Vendor Self-Service (VSS) portal when bidding on contracts 2. Replace CPPS in the future 3. KRONOS (time-keeping system) to supplement Clarity	
Failures of the Current Process: 1. Failure to account for expenditures in accordance with GAAP can result in disallowance and/or retraction of federal funding participation	
Notes:	

Manage Accounts Payable Disbursement– FM14

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Accounts Payable Management
Business Process: Manage Accounts Payable Disbursement
Author(s): Marta Fyffe, Sandy Salus, Clark Akins, Ben Drendel, Bret Pittenger, Sharon Brydon, Sandra Bowen, Sado Tesfaye, Greg Tanner
Facilitator: Nicole Wong
Actor(s): Providers, contractors, Fiscal Agent, Department staff

MITA 3.0 Business Process Description:
The **Manage Accounts Payable Disbursement** business process that is responsible for managing the generation of electronic and paper-based reimbursement instruments, which includes:
• Calculation of payment amounts fee-for-service claims, pharmacy point-of-sale, and Home and Community-Based Services (HCBS) based on:
  ○ Priced claim, including any Third-Party Liability (TPL), and crossover or member payment adjustments
  ○ Retroactive rate adjustments
  ○ Adjustments for previous incorrect payments, taxes, performance incentives, recoupments, garnishments, and liens based on information in the Provider data store, as well as state accounting and budget rules
  ○ Payroll processing (e.g., for HCBS providers), which includes withholding payments for payroll, federal and state, taxes, as well as union dues
  ○ Application of automated or user-defined adjustments based on contract (e.g., adjustments or performance incentives)
• Disbursement of payment from appropriate funding sources per state and the State Medicaid Agency (SMA) accounting and budget rules including:
  ○ Managed Care Organization (MCO) per member per month premium
  ○ Health Insurance Premium Payment (HIPP) Program premium
  ○ Medicare premium
  ○ Primary Care Case Managers (PCCM) fee
  ○ Stop-loss payment
  ○ PCCM management fee
  ○ Health Insurance Flexibility and Accountability (HIFA) waiver small employer refunds (i.e. Parents of children enrolled in Children's Health Insurance Program (CHIP))
• If applicable, association of the Electronic Funds Transfer (EFT) with an Accredited Standards Committee (ASC) X12 835 Health Care Claim Payment/Advice or ASC X12 820

Payroll Deducted and Other Group Premium Payment for Insurance Products transaction
- Routing of the payment per the provider or contractor data store payment instructions for EFT or check generation and mailing
- Alert sent to the **Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area) with updated suspended and paid claims transaction accounting details
- Alert sent to the **Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area) with updated suspended and paid premium, fees, and stop-loss claims transaction accounting details

The SMA will support frequency of payments under the federal Cash Management Improvement Act (CMIA), including real-time payments where appropriate (e.g., Pharmacy Point-of-Sale).

CO Business Process Description:
Colorado's **Manage Accounts Payable Disbursement** business process is generally aligned with the MITA 3.0 Framework. CORE will support additional data requirements to allow better association of financial information.

Precondition:
- **Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area)
- **Manage Provider Information (PM01)** business process (part of the Provider Management business area)
- **Manage Capitation Payment (FM11)** business process (part of the Financial Management business area)
- **Manage Incentive Payment (FM12)** business process (part of the Financial Management business area)
- **Process Claim (OM07)** business process (part of the Operations Management business area)
- **Process Encounter (OM29)** business process (part of the Operations Management business area)
- **Manage Performance Measures (PL05)** business process (part of the Plan Management business area)
- **Generate Remittance Advice (OM14)** business process (part of the Operations Management business area)
- **Manage Member Financial Participation (FM10)** business process (part of the Financial Management business area)
- **Prepare Provider Payment (OM27)** business process (part of the Operations Management business area)

Manage Accounts Payable Disbursement– FM14

***Trigger(s)*:**

1. Receive payment request from the **Process Claim (OM07)** business process (part of the Operations Management business area)
2. Receive payment request from the **Process Encounter (OM29)** business process (part of the Operations Management business area)
3. Receive premium fee or stop-loss claim information from the **Manage Member Financial Participation (FM10)** (part of the Financial Management business area) or **Prepare Provider Payment (OM27)** business processes (part of the Operations Management business area)
4. Receive payment request from the **Manage Capitation Payment (FM11)** business process (part of the Financial Management business area)
5. Receive payment request from the **Manage Incentive Payment (FM12)** business process (part of the Financial Management business area)

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** request and information from other business processes
2.		**Prepare Provider/Contractor Payment:**
a.	M/A	**Apply** automated or user-defined payment calculation rules (e.g., deducting tax per rates in provider files, garnishments, and liens) by accessing information from provider files and sending an alert to the **Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area)
3.		**Payroll Payment**
a.	M/A	**Trigger** Central Payroll functions. **Perform** all payroll liability deductions
4.		**Prepare Premium Payment:**
a.	M/A	**Receive** premium payment information from the **Manage Member Financial Participation (FM10)** (part of the Operations Management business area) or **Prepare Provider Payment (OM27)** business processes (part of the Operations Management business area)
b.		**Apply** automated or user-defined payment calculation rules such as risk adjustment and stop-loss claims, retrospective enrollment, and performance incentives
5.	M/A	**Disburse** funds as specified by the state and the SMA accounting and budget business rules
6.	M/A	**END**: **Route** payments as specified by the provider or contractor pay-to instruction or based on information submitted in the standard claim transactions

***Outcome*:**

1. Provider or contractor received payment either by EFT or check

<table>
<tr><td colspan="2">2. Trigger ASC X12 820 or 835 Payment Order/Remittance Advice transaction for payment to provider or contractor
3. Tracking information as needed for measuring performance and business activity monitoring</td></tr>
<tr><td>As Is Performance Metrics:
• Pay claims within 60 days from date receipt of clean claim.
• Payment has to be available to provider 3 business days prior to the payment date or 3 business days after the payment date for 90% of claims. To be compliant with the Core Operating Rule.

Supporting Performance Metrics/SLA Documentation:
• Federal Rule 370 – Core Operating Rule
• State Medicaid Manual
• GASB, GAAP, CMIA</td><td>To Be Performance Metrics:
• Same as As-Is</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. MMIS
2. Benefit Solvers – run by benefit administrator to change the employee benefits
3. CPPS
4. COFRS/CORE</td><td>Shared Data/Interfaces, Outbound:
5. CPPS
6. MMIS
7. COFRS/CORE
8. Financial Data Warehouse (FDW)
9. HR DW
10. Document Direct (static reporting tool)
11. DW/DSS
12. Employee Self-Service (ESS)</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. Health Benefit data store including benefit information and fee schedules
2. Authorization data store including authorization and treatment plan information
3. Replace CPPS in the future</td></tr>
<tr><td colspan="2">Failures of the Current Process:
1. Calculation of payment and application of payment adjustments may lack accurate information or be inaccurate
2. Entity failed to receive EFT or check or payee returns the check
3. Unable to process payment due to a mutilated, destroyed or stale dated check</td></tr>
</table>

4. Matching up of the Remittance Advice and Electronic Funds Transfer (EFT) 5. Remittance Advice is not matched up with the paper check
Notes:

CO MITA 3.0 SS-A Project

Business Area: Financial Management		
Business Category: Accounts Payable Management		
Business Process: Manage 1099		
Author(s): Clark Akins, Marta Fyffe, Ben Drendel, Sam Seligman, Jocelyn Parker, Nathan Culkin, Sandy Salus		
Facilitator: Amy Mazeski		
Actor(s): State Controller's Office, Accounting Staff, Vendors, Contractors, Providers		
MITA 3.0 Business Process Description: The **Manage 1099** business process describes how the State Medicaid Agency (SMA) handles IRS 1099 forms including preparation, maintenance, and corrections. Any payment or adjustment in payment made to a single Social Security Number (SSN) or federal Tax ID Number (TIN) impacts the business process. The **Manage 1099** business process receives payment and/or recoupment information from the **Process Claim (OM07)** business process (part of the Operations Management business area) or from the **Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area). The **Manage 1099** business process may also receive requests for additional copies of a specific IRS 1099 form or receive notification of an error or a needed correction. The business process provides additional requested copies via the **Manage Provider Communication (PM02)** (part of the Provider Management business area) or **Manage Contractor Communication (CO02)** (part of the Contractor Management business area) business processes. Staff researches error notifications and requests for corrections for validity and generate a corrected 1099 or a brief explanation of findings. ***CO Business Process Description:*** Colorado's **Manage 1099** business process is generally aligned with the MITA 3.0 Framework. The brief explanation of findings doesn't occur, there is a nightly reconciliation of errors in W-9 processing in COFRS/CORE.		
Precondition: • Contractor/Vendor/Provider entity that meets 1099 criteria		
Trigger(s): 1. Receipt of W-9		
Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Establish** or **modify** contractor/vendor/provider record in COFRS

2.	M/A	Contractor/Vendor/Provider **receives** payment for goods or services
3.	A	State Controller's Office **runs** calendar year end 1099 process
4.	M	Accounting staff **reviews** 1099 report and applies corrections as necessary
5.	M/A	**END**: State Controller's Office **produces** and **delivers** 1099 forms

***Outcome*:**
1. 1099 forms are created and delivered

As Is Performance Metrics:	***To Be Performance Metrics:***
• All 1099s have to be mailed by January 31st annually • All corrections and completed and distributed by April 15th annually ***Supporting Performance Metrics/SLA Documentation:*** • IRS Guidelines	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. COFRS/CORE (Payment information) 2. W-9 (IRS Information) 3. MMIS (Payment information) 4. IRS	***Shared Data/Interfaces, Outbound*:** 1. 1099s to contractors /vendors/providers

To Be Future Vision:
1. Contractors/ Vendors / Providers to keep their information current
2. Current / updated provider information entered into MMIS
3. Online provider enrollment
4. Electronic signature

Failures of the Current Process:
1. Incorrect addresses for delivery
2. Human error – fill out the W-9 incorrectly
3. Manual process – data entry errors
4. Volume of 1099s to be reviewed manually
5. Lack of resources to research returned 1099s

Notes:

Formulate Budget – FM16

CO MITA 3.0 SS-A Project

Business Area: Financial Management

Business Category: Fiscal Management

Business Process: Formulate Budget

Author(s): Clark Akins, Marta Fyffe, Ben Drendel, Sam Seligman, Jocelyn Parker, Nathan Culkin, Sandy Salus

Facilitator: Amy Mazeski

Actor(s): Budget staff, Office of State Planning and Budgeting (OSPB), Joint Budget Committee (JBC), Legislative Council, Department Staff

MITA 3.0 Business Process Description:

The **Formulate Budget** business process:

- Examines the current budget revenue stream and trends, and expenditures.
- Assesses external factors affecting the program.
- Assesses agency initiatives and plans.
- Models different budget scenarios.
- Periodically produces a new budget.

CO Business Process Description:

Colorado's **Formulate Budget** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- Develop Agency goals and objectives
- Performance measures
- Policy
- Appropriation or identified need

Trigger(s):

1. Scheduled date for State budget process
2. Notification of a revenue shortfall or surplus
3. Legislation

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Identify** need for budget action
2.	M	Executive Committee **approves** budget action
3.	M	**Write** and **submit** budget action to OSPB
4.	M	**Submit** budget action to JBC
5.	M	JBC, Legislature, and Governor **approve** or **deny** budget action through legislation
6.	M	If approved, the Department's budget **receives** notification of

		appropriation
7.	M	**END**: **Notify** Department staff of updated budget

Outcome:
1. Revised budget
2. An appropriation, a bill, or a decision by the State Controller

As Is Performance Metrics:	***To Be Performance Metrics:***
• Annual calendar published by OSPB that governs budget activities. Department obligated to meet these deadlines ***Supporting Performance Metrics/SLA Documentation:*** • State Statute – C.R.S. 2-3-208 (2013) budget-related deadlines • OSPB Website	• Potential measures related to budgeting resulting from CORE functionality
Shared Data/Interfaces, Inbound: 1. COFRS/CORE 2. OSPB 3. JBC 4. MMIS (update GL Codes) 5. Open drive (internal staff information repository) 6. SharePoint 7. DSS 8. CBMS	***Shared Data/Interfaces, Outbound***: 1. SharePoint 2. Open drive (internal staff information repository) 3. OSPB 4. JBC 5. COFRS/CORE 6. Other State Agencies 7. Federal Partners 8. Department External Website

To Be Future Vision:
1. Electronic budget submission system
2. Complete financial management system through the DSS
3. Enhanced Data Warehouse
4. 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 of the Current Process:
1. Forecast errors
2. Incomplete data
3. Political environment
4. Competing priorities
5. Inconsistency between budget schedule and operational needs
6. Lack of communication between systems (e.g., not all caseload data captured in MMIS,

systematic discrepancies between the MMIS/DSS and COFRS) 7. Communication between budget staff and other Department staff and other entities (e.g. Departments, Legislative staff, contractors) 8. Conflicting guidance from federal partners 9. Mismatch between state and federal budget process (deadlines, quarterly vs. annual, etc.)
Notes:

Manage Budget Information–FM17

CO MITA 3.0 SS-A Project

Business Area: Financial Management		
Business Category: Fiscal Management		
Business Process: Manage Budget Information		
Author(s): Ben Drendel, Rene Horton, Renee Strebelinski, Brad Shipley, Nathan Culkin		
Facilitator: Kristin Sparks		
Actor(s): Budget staff, Office of State Planning and Budgeting (OSPB), Joint Budget Committee (JBC), Legislative Council, Department staff, other State departments		
MITA 3.0 Business Process Description: The **Manage Budget Information** business process is responsible for auditing all planned expenses and revenues of the State Medicaid Agency (SMA). Activities in this business process comply with Cash Management Information Act (CMIA), Governmental Accounting Standards Board (GASB) standards and Generally Accepted Accounting Principles (GAAP). ***CO Business Process Description:*** Colorado's **Manage Budget Information** business process is generally aligned with the MITA 3.0 Framework. Colorado has noted that the CMIA, GASB, and GAAP standards are not applicable to this process.		
Precondition: • **Formulate Budget** (part of the Financial Management business area) • Agency goals and objectives • Performance measures • Policy • Appropriation		
Trigger(s): 1. Receive request to review budget information (e.g., funding requirements, funding sources) 2. Notification of a revenue shortfall or surplus		
Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** request internally or externally to review or modify approved budget or regularly scheduled budget review
2.	M	**Review** the budget request against state and federal requirements, as well as appropriation documentation to **ensure** that the budget is appropriately aligned with legislative intent and Department policy
3.	M	**Determine** if budget action is required. If yes, trigger **Formulate Budget**

		business process (part of Financial Management business area). If no, **continue** to next step.
4.		**END**: **Modify** budget information and **communicate** changes to other Department staff as necessary

Outcome:
1. Modified budget information
2. Tracking information as needed for measuring performance and business activity monitoring
3. Completed Schedule 3 for Department's state budget documents

As Is Performance Metrics:	***To Be Performance Metrics:***
• State budget calendar and guidelines (OSPB) • Internal budget division performance metrics ***Supporting Performance Metrics/SLA Documentation:*** • State Statute – C.R.S. 2-3-208 (2013) • OSPB Website • Department SOPs	• Potential measures related to budgeting resulting from CORE functionality • Same as As-Is • Strategic Plan for the Department
Shared Data/Interfaces, Inbound: 1. COFRS/CORE 2. MMIS 3. DSS 4. Standard spreadsheets 5. Access Database for CHIP data 6. SharePoint 7. Open Drive 8. CBMS 9. JBC and OSPB websites 10. Department external facing website	***Shared Data/Interfaces, Outbound***: 1. Department external facing website 2. Standard spreadsheets 3. SharePoint 4. Open Drive 5. All Payer Claims Database (APCD) 6. Federal Partners (CMS 37/64)

To Be Future Vision:
1. Bidirectional interfaces between DSS, CORE, CBMS, MMIS, CORHIO, APCD
2. Generate an automated alert to program staff at predefined benchmarks of spending against budget
3. Automate processes to monitor expenditures against the budget

Failures of the Current Process:
1. Forecast errors
2. Incomplete data
3. Political environment
4. Competing priorities

5. Inconsistency between budget schedule and operational needs 6. Lack of communication between systems (e.g., not all caseload data captured in MMIS, systematic discrepancies between the MMIS/DSS and COFRS) 7. Communication between budget staff and other Department staff and other entities (e.g. Departments, Legislative staff, contractors) 8. Human error 9. Manual processes lead to issues with timeliness 10. Conflicting guidance from federal partners 11. Mismatch between state and federal budgeting process
Notes:

Manage Fund – FM18

CO MITA 3.0 SS-A Project

Business Area: Financial Management
Business Category: Fiscal Management
Business Process: Manage Fund
Author(s): Ben Drendel, Rene Horton, Renee Strebelinski, Brad Shipley, Nathan Culkin
Facilitator: Kristin Sparks
Actor(s): Fiscal Agent, Department Staff, Providers, Attorney General, MFCU Staff, CMS, Other State Departments

MITA 3.0 Business Process Description:

The **Manage Fund** business process oversees Medicaid funds, ensures accuracy in their allocation and the reporting of funding sources. Funding for Medicaid services may come from a variety of sources, and often, state funds span across state agency administrations, e.g., Mental Health, Aging, Substance Abuse, physical health, as well as state counties and local jurisdictions. The **Manage Fund** business process monitors funds through ongoing tracking and reporting of expenditures and corrects any improperly accounted expenditure. It also deals with projected and actual over and under fund allocations.

Manage Federal Medical Assistance Percentages (FMAP)

The Manage FMAP activity periodically reviews and modifies, as appropriate, FMAP and Enhanced Federal Medical Assistance Percentages (enhanced FMAP) rate used. (See 42 CFR 433.10). The U.S. Department of Health & Human Services (HHS) notifies the state of the FMAP and (enhanced FMAP) that HHS will use in determining the amount of federal matching for state medical assistance (Medicaid), Children's Health Insurance Program (CHIP), and Recovery Audit Contractor (RAC) expenditures for a specified federal fiscal year. The State Medicaid Agency (SMA) reviews and approves the FMAP rates for application in enterprise accounting.

Manage Federal Financial Participation (FFP)

The Manage FFP business activity includes the creation and management of business rules for assigning claims, service payments, and recoveries (including RAC recoveries) to the appropriate FMAP, and the application of administrative costs to the state accounting system. It also includes the oversight of reporting and monitoring Advance Planning Documents or other program documents necessary to secure and maintain FFP.

Draw and Report FFP

The Draw and Report FFP business activity assures that the SMA properly draws federal funds and reports to Centers for Medicare & Medicaid Services (CMS). The SMA is responsible for assuring that the correct FFP rate applies to all expenditures in determining the amount of federal funds to draw. When CMS has approved a Medicaid State Plan, it

makes quarterly grant awards to the SMA to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the SMA to draw federal funds as needed in accordance with the Cash Management Improvement Act (CMIA) to pay the federal share of disbursements. The SMA receives FFP in expenditures for the CHIP program.

CO Business Process Description:

Colorado's **Manage Fund** business process is generally aligned with the MITA 3.0 Framework. In Colorado, 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 clients 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)
- MAGI match
- OAP (Old Age Pension) match is state only (0% FFP)

Precondition:

- Service has been provided
- A claim has been submitted for the service
- System enhancements or System replacement
- Approved APD or APDUs
- Fiscal Agent and State operations
- Approved grants

***Trigger(s)*:**

1. Identify need for adjustment
2. Receipt of notification to apply appropriate fund splits to expenditures or recoveries

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** payment request (e.g., claim, invoice, payroll)
2.	M/A	**Determine** appropriate fund splits to be applied
3.	M/A	**Pass** or **input** data to COFRS for payment requests
4.	A	COFRS REVA process **draws** federal funds based on determined fund splits
5.	M/A	**Draw** the funds through Federal Payment Management System and **verify** COFRs and PMS match
6.	M/A	**END**: **Generate** CMS 64 report for funding requests

***Outcome*:**

<table>
<tr><td colspan="2">1. Expenditure and recovery data with applied fund splits
2. CMS 64 report
3. Remain interest neutral in compliance with CMIA timelines</td></tr>
<tr><td>As Is Performance Metrics:
• CMS 64 report must be filed by 30th day of the month following the quarter
• CMS 37 report must be filed by the middle of the preceding quarter
• Remain interest neutral in compliance with CMIA timelines

Supporting Performance Metrics/SLA Documentation:
• CMS 64 and CMS 37 Report
• CMIA</td><td>To Be Performance Metrics:
• Same as As-Is</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. COFRS/CORE
2. MMIS
3. DSS
4. ESUR
5. PDCS
6. BUS
7. CMS
8. Payment Management System (PMS)
9. MBES/CBES
10. Appropriation data</td><td>Shared Data/Interfaces, Outbound:
1. MBES/CBES
2. COFRS/CORE
3. CMS</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. Ability to reconcile MMIS with COFRS/CORE
2. Increase automation
3. Paperless
4. Increase the number of GL codes and make it easier to add GL codes
5. Trace numbers on all transactions between CORE and MMIS</td></tr>
<tr><td colspan="2">Failures of the Current Process:
1. COFRS/CORE tables not loaded correctly
2. Human Error – without understanding of expenditure and how they should be paid, wrong fund splits can be applied
3. If GL codes are not loaded correctly, MMIS payments do not interface with COFRS/CORE correctly (and will not get paid)
4. Multiple manual workarounds to associate expenditures with proper fund splits, requires Data, Budget, and Accounting staff to complete (e.g., family planning reporting process)
5. Audit findings faulting the use of manual workarounds to move expenditures between accounting / CMS reporting lines</td></tr>
</table>

Notes:

Generate Financial Report– FM19

CO MITA 3.0 SS-A Project

Business Area: Financial Management

Business Category: Fiscal Management

Business Process: Generate Financial Report

Author(s): Brian Knight, Nathan Culkin, Sam Seligman, Rene Horton, Ben Drendel, Brad Shipley

Facilitator: Amy Mazeski

Actor(s): CMS, Fiscal Agent, Contractors, Legislature, Providers, County workers, public, Other State departments, Department staff

MITA 3.0 Business Process Description:

It is essential for the State Medicaid Agency (SMA) to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the established benefits and programs are meeting the needs of the member population and are performing according to the intent of the legislative laws or federal reporting requirements.

The **Generate Financial Report** business process begins with a request for information or a timetable for scheduled correspondence. The business process includes:

- Defining the report attributes (e.g., format, content, frequency, media, and retention)
- Defining the state and federal budget categories of service, eligibility codes, provider types, and specialties (taxonomy)
- Extracting required financial information from source data stores
- Transforming information to meet business and technical needs of target destination
- Applying necessary encryption algorithms for security
- Sending alert with information to the target destination

NOTE: This business process does not include maintaining the benefits, reference, or program information. Maintenance of the health plan, health benefits, and reference information is in separate business processes.

CO Business Process Description:

Colorado's **Generate Financial Report** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- Defining the Department goals and objectives
- State and federal reporting requirements

Trigger(s):

1. Scheduled reporting dates (e.g. CMS64 and CMS37, or State legislative reporting)

2. Ad hoc reporting request

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START: Receive** request for generation of financial report
2.	M/A	If not predefined, **define** required report(s) format, content, frequency, media for the reports, and its retention period
3.	M/A	If not predefined, **define** data elements necessary to produce the report (e.g., state and federal budget categories of service, eligibility codes, taxonomy codes)
4.	M/A	**Extract** required information from source data stores
5.	M/A	If applicable, **transform** information to meet business and technical needs of target destination
6.	M/A	**Conduct** clearance review of report prior to distribution
7.	M	If applicable, **apply** necessary encryption algorithms for security
8.	M/A	If applicable, **send** the report to requestor
9.	M	END: **Archive** financial report

Outcome:

- The ad hoc or scheduled generation of a financial report such as the following:
  - CHIP Program Budget Report (CMS-21B)
  - Medicaid Program Budget Report (CMS-37)
  - Quarterly CHIP Statement of Expenditures (CMS-21)
  - Quarterly Expense Report (CMS-64)
  - Monthly JBC Report
  - Refugee Report
- The financial and program analysis report set sent
- Tracking information as needed for measuring performance and business activity monitoring

As Is Performance Metrics:

- CMS 64 report must be filed by 30th day of the month following the quarter
- CMS 37 report must be filed by the middle of the preceding quarter

Supporting Performance Metrics/SLA Documentation:

- CMS 64 and CMS 37 Report
- Legislative Deadlines

To Be Performance Metrics:

- Same as As-Is
- Improve efficiency and accuracy around development of federal financial reports

Shared Data/Interfaces, Inbound:

1. MMIS
2. DSS
3. CBMS
4. MHSIP

Shared Data/Interfaces, Outbound:

1. Website
2. Spyder
3. MBES/CBES

5. YSS 6. YSS-F 7. SDAC 8. PDCS 9. MBES/CBES 10. COFRS/CORE	4. COFRS/CORE

To Be Future Vision:

1. Report request and response tracking log
2. Improve efficiency and accuracy around development of federal financial reports
3. EHR (HIE) to support incentive and shared savings payment information
4. Bi-directional interface between BUS and CBMS
5. Bi-directional interface between CBMS and MMIS
6. New BUS integrated into New MMIS
7. New DSS (true data warehouse with data marts)
8. Improved integration of data - TRAILS and CBMS to MMIS
9. Incorporation of other datasets into MMIS / DSS (i.e. COFRS, BENDEX, SDX, etc.)
10. Access to external data sources: vital statistics, DORA, State Demographer's Office
11. Improved integration of PDCS data and MMIS
12. Automated reporting to CMS
13. Automated extract to the all payers claims database (APCD)
14. Real-time data (near real-time)
15. Real-time notification of services immediately before they are used (ER and Hospitalization)
16. Ability to risk adjust the data
17. Geocoding and mapping capabilities integrated with DSS
18. 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 of the Current Process:

1. Data availability
2. Data timeliness
3. Data format
4. Cost – CSRs, purchasing data, and Vital Statistics
5. Complexity of the report
6. Staff availability / resource constraints
7. Privacy concerns (Vital Statistics)
8. Clear management decisions and directives
9. Limited integrated mapping capabilities, no geocoding capability
10. Limited access to specialized software to prepare and report measures (e.g. statistical and mapping software)

Notes:

Generate Financial Report– FM19

6 – Member Management Use Cases

Manage Member Information–ME01

CO MITA 3.0 SS-A Project

Business Area: Member Management (ME) - Under Development
Business Category: Member Information Management (Future Release)
Business Process: Manage Member Information
Author(s): Brian Knight, Nathan Culkin, Sam Seligman, Rene Horton, Ben Drendel, Brad Shipley; Shawn Bodiker; Terry Burnham
Facilitator: Amy Mazeski
Actor(s): Client, Other State and Government Entities, Department Staff, Fiscal Agent, Utilization Management Contractor, Enrollment Broker
MITA 3.0 Business Process Description: **NOTE**: Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Eligibility & Enrollment (Member), the Member Management business processes or business capability matrices, and a portion of the Concept of Operations (COO) outlining the "to-be" for eligibility, enrollment, and insurance exchange information. CMS will update the MITA 3.0 Framework with appropriate information from the final rules. ***MITA 2.0 Business Process Description:*** The **Manage Member Information** business process is responsible for managing all operational aspects of the Member Registry, which is the source of comprehensive information about applicants and recipients, and their interactions with the state Medicaid Agency. The Member Registry is the Medicaid enterprise "source of truth" for recipient demographic, financial, socio-economic, and health status information. A recipient's registry record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a recipient may receive a customized set of services. In addition, the Member Registry stores records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment, the recipient's covered services, and all communications, e.g., outreach and EOBs, and interactions related to any Grievance/appeal. The Member Registry may store records or pointers to records for services requested and services provided, care management, utilization and program integrity reviews, and recipient payment and spend-down information. Business processes that generate applicant or recipient information send requests to the Member Registry to add, delete, or

change this information in registry records. The Member Registry validates data upload requests, applies instructions, and tracks activity.

The Member Registry provides access to recipient records to applications and users via batch record transfers, e.g., for Medicare Crossover claims processing, responses to queries, e.g., for eligibility verification and **Operations Management** business area, and "publish and subscribe" services for business processes that track recipient eligibility, e.g., **Care Management** business area and the **Perform Population and Member Outreach (ME03)** business process (part of the Member Management business area).

CO Business Process Description:
Colorado's **Manage Member Information** business process is generally aligned with the MITA 3.0 Framework. It 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.

Precondition:
- Enrolled client

***Trigger(s)*:**
1. Receive updated client information from client, provider, or eligibility assistance site
2. Required SEP monitoring activities
3. Service provided and claim submitted
4. Utilization Management (UM) requests
5. RRR – Redetermination/Recertification/Reassessment
6. Receipt of client grievance or appeal
7. Receipt of interfaces from other agencies that affects client information
8. Time triggers within system (e.g. age, pregnancy, completion of program) that affect client information

Manual (M) or Automated (A)		***Steps:***
		Receive Update Client Information:
1.	M/A	**START**: **Receive** data change/update
2.	M/A	**Enter** new information in CBMS
3.	A	**Pass** information through interface from CBMS to MMIS
4.	A	**END**: **Load** information into MMIS
		SEP Monitoring and LTC Client reassessment:

1.	M	**START**: SEP **enters** data into BUS
		Claims:
1.	M/A	**START**: Provider **submits** claim for service to MMIS
2.	A	**Process** claim through edits
3.	A	**END**: **Load** information into MMIS
		UM Requests:
1.	M/A	**START**: Provider **submits** request to reviewing agencies
2.	M/A	Reviewing agencies **reviews** request
3.	M/A	Request is **approved** or **denied**
4.	M/A	Approval/Denial **entered** in MMIS
5.	M/A	**END**: **Load** information into MMIS
		RRR: (Redetermination/Recertification/Reassessment)
1.	M/A	**START**: **Send** automated RRR to client
2.	M	Client **returns** completed form, if there are changes
3.	M/A	**Enter** updated information into CBMS
4.	A	**Pass** information through interface from CBMS to MMIS
5.	A	**END**: **Load** information into MMIS
		Grievance and Appeal:
1.	M	**START**: **Receive** grievance or appeal
2.	A	**END**: **Track** appeals in CBMS

***Outcome*:**

1. Client information is updated and maintained

As Is Performance Metrics:	***To Be Performance Metrics:***

• Client information updates need to be completed within 10 business days of receipt
• CBMS has to submit the data to MMIS by 6pm MT each business day
• MMIS has to load the information from CBMS by 7am MT the following business day
• Daily Medical Extract (DME) File Processing Schedule
  ○ TRAILS will generate the TRAILS DME case and client files and submit to CBMS by 6AM
  ▪ The TRAILS client file will include all individuals that were updated in TRAILS by 2AM
  ▪ If the individual is updated after 2AM, they will be included in the next business day's TRAILS file
	• Same as As-Is

○ CBMS will combine the TRAILS DME files and the CBMS DME files and will generate the DME case and client files and submit to MMIS by 6PM ▪ The CBMS client file will include all individuals that were on-line authorized in CBMS (includes PEAK and all modes) prior to 4PM ▪ If the individual is new to CBMS, they will be included in the same day file ▪ If the individual is known in CBMS, they will be included in the next business day's file ▪ If the individual is authorized after 4PM, they will be included in the next business day's file ▪ If the individual is authorized in the EDBC batch processing, they will be included in the next business day's file ○ MMIS will submit the DME files to Xerox immediately upon receipt from CBMS ○ Xerox will process the DME files to guarantee the data is visible in the MMIS by 7AM the next business day ○ DME process will run Monday – Friday excluding holidays ▪ If an individual is authorized on Saturday, Sunday, or a holiday, they will be included in the next business day's file • Monthly Medical Extract (MME) File Processing Schedule ○ Trails will generate the Trails MME case and client files and submit to CBMS at a time agreed upon between CBMS and Trails ○ CBMS will combine the Trails MME files with the CBMS MME files and will generate the MME case and client files to MMIS by 10AM on the last Saturday of every month	

○ MMIS will submit the MME files to Xerox immediately upon receipt from CBMS ○ Xerox will process the MME files to guarantee the data is visible in MMIS by 7AM Monday morning ○ On Friday prior to the last Saturday of every the month, Trails/CBMS will generate normal **DME** case and client files and submit to MMIS 6PM. ○ MMIS will submit Friday's **DME** files to Xerox immediately upon receipt from CBMS ○ Xerox will process Friday's **DME** files to guarantee the data is visible in the MMIS by 7AM Saturday ○ On Friday evening prior to the last Saturday of every month, Trails/CBMS will generate the **MME** files and submit to MMIS by 10AM Saturday ○ MMIS will submit the **MME** files to Xerox immediately upon receipt from CBMS ○ Xerox will process the **MME** files to guarantee the data is visible in the MMIS by 7AM Monday • The eligibility site shall promptly re-determine eligibility when: ○ It receives and verifies information which indicates a change in a client's circumstances which may affect continued eligibility for Medical Assistance; or ○ It receives direction to do so from the Department ○ The eligibility site shall re-determine eligibility according to timelines defined by the Department ***Supporting Performance Metrics/SLA Documentation:*** • MMIS Operating Procedure for loading CBMS data • Department User Reference Guide • 8.100.3P Redetermination of Eligibility	

Manage Member Information– ME01

Shared Data/Interfaces, Inbound:	***Shared Data/Interfaces, Outbound:***
1. CBMS 2. MMIS 3. DSS 4. BUS 5. TRAILS 6. UM Contractor System 7. SEP – PEAK 8. DDDWeb 9. Other government entities interfaces	1. SEP – PEAK 2. C4 Health Colorado
To Be Future Vision: 1. A way to verify or check for address or contact information for clients 2. Real-time interface between CBMS and MMIS 3. Collect health status information for all clients – mandatory field, with option to not respond 4. More accurate way to collect client demographics and socio-economic information 5. Standardized demographic options (i.e. race/ethnicity fields consistent with U.S. Census Bureau options) 6. Ability to accept EHR information into MMIS 7. Require entry of health status information 8. NEW DSS 9. New BUS 10. Expand to multi-languages 11. Communication should be language and literacy appropriate 12. Integration of the BUS and DDDWeb	
Failures of the Current Process: 1. No ability for multi-language access 2. Clients don't receive and/or understand the request to provide updated information 3. Difficult or impossible to locate/contact clients who have moved or changed telephone numbers 4. Incorrect information provided and data entry errors	
Notes: No client information enters the BUS automatically from any other system. The BUS does not pass any information automatically to any other system.	

Manage Member Information–ME01

Manage Applicant and Member Communication – ME02

CO MITA 3.0 SS-A Project

Business Area: Member Management (ME) - Under Development
Business Category: Member Support (Future Release)
Business Process: Manage Applicant and Member Communication
Author(s): Joey Gallegos, Brian Knight, Leah Jardine, Jerry Smallwood, Brad Shipley, Jeff Helm
Facilitator: Nicole Wong
Actor(s): Clients, Prospective Clients, Applicants, Eligibility Workers, State Staff, ID Card Contractor, Office of Administrative Courts, Providers, Enrollment Broker, PEAK, SEPs
MITA 3.0 Business Process Description: **NOTE**: Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Eligibility & Enrollment (Member), the Member Management business processes or business capability matrices, and a portion of the Concept of Operations (COO) outlining the "to-be" for eligibility, enrollment, and insurance exchange information. CMS will update the MITA 3.0 Framework with appropriate information from the final rules. ***MITA 2.0 Business Process Description:*** The **Manage Applicant and Member Communication** business process receives requests for information, appointments and assistance from prospective and current recipient's communications such as inquiries related to eligibility, redetermination, benefits, providers; health plans and programs, and provides requested assistance and appropriate responses and information packages. Communications are researched, developed and produced for distribution via **Send Outbound Transaction** process. NOTE: Inquires from applicants, prospective and current recipients are handled by the **Manage Applicant and Member Communication** process by providing assistance and responses to individuals, i.e., bidirectional communication. Also included are scheduled communications such as Recipient ID cards, redetermination notifications, or formal program notifications such as the dispositions of grievances and appeals. The **Perform Applicant and Member Outreach (ME03)** (part of the Member Management business area) process targets both prospective and current recipient populations for distribution of information about programs, policies, and health issues. ***CO Business Process Description:*** Colorado's **Manage Applicant and Member Communication** business process is generally

aligned with the MITA 2.0 Framework.

In addition, this process includes **inbound inquiries** and **outbound responses** related to:

- 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)

Note that for newly enrolled EPSDT (age 0 – 20) clients are mailed an Enrollment Package from Health Colordao and are called by a Healthy Communities Family Health Coordinator within the first 60 days of enrollment.

Precondition:

- Client, Potential Client, Provider, Advocates need for information

***Trigger(s)*:**

1. Request for information regarding eligibility – lost ID card, program information, denied, partial approval, and approval prior authorization request
2. Scheduled communications – Reassessment, Redetermination, and Recertification (RRR), Medicaid ID cards, LTC reauthorization, Notice of Action, change in benefit status
3. Enrollment for EPSDT clients triggers an Enrollment Package be sent and a Family Health Coordinator call

Manual (M) or Automated (A)		***Steps:***
		Request for Information:
1.	M/A	**START**: **Receive** request for information
2.	M/A	**END**: **Provide** information
		System Generated Communications – RRR and Notice of Action:
1.	M/A	**START**: **Send** RRR packet to client
2.	M/A	Client **returns** completed forms
3.	M	**END**: **Enter** updated information in CBMS
		Scheduled Communications – Medicaid ID Cards:
1.	M/A	**START**: **Enroll** client in CBMS or Trails
2.	M/A	**Send** client record to the Medicaid ID card request file from CBMS or Trails
3.	A	**Merge** Trails and CBMS Medical ID Card Request files into a single interface file from CBMS
4.	A	**Send** Medical ID Card Request file to State from CBMS
5.	A	**Send** Medical ID Card Request file to external Medical ID Card Vendor from State
6.	A	**END**: External Medical ID Card Vendor **prints** and **mails** Medical ID cards to clients

Manage Applicant and Member Communication – ME02

		LTC Reauthorization Communication:
1.	M	**START**: SEP case manager **tracks** LTC functional eligibility date spans
2.	M	SEP case manager **initiates** outreach efforts to re-evaluate continuing functional need within 90 days of the certification end date
3.	M	SEP case manager **determines** functional eligibility
4.	M	SEP case manager **communicates** outcome communicated County income maintenance technician
5.	M	County income maintenance technician **updates** the Benefits Utilization System (BUS)
6.	M	**END**: Notice of Action is **sent** to the client

***Outcome*:**
1. Information provided
2. Clients able to obtain services

As Is Performance Metrics:	***To Be Performance Metrics:***
• Recognition of request within 48 hours of receipt • Turnaround times associated with ID cards ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Recognition within 48 hours of request
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS 3. CBMS 4. TRAILS 5. Contractor ftp site 6. BUS 7. PEAK 8. COLD 9. Clients: phone calls, emails 10. Other Agency Interfaces: DMV, DOLE, etc. 11. Health Communities Client Relations Management System (SalesForce based)	***Shared Data/Interfaces, Outbound*:** 1. PEAK 2. ID Card Contractor 3. Contractor FTP site 4. Connect for Health Colorado 5. Clients: phone calls, emails, letters 6. TRAILS

To Be Future Vision:
1. Less manual processes with the system
2. Addresses for all clients, not just head of household
3. Auto-generated notices sent at milestones during enrollment processes (Currently happens for EPSDT clients. They receive two different types of contacts within the first

60 days). 4. Eliminate duplicate notifications to clients 5. Make paper communication optional 6. Interface with address correction/update service to obtain up-to-date client contact information so client communications can be successfully completed 7. Easily identify all members of a family; capability of linking mothers and babies 8. State-wide document repository
Failures of the Current Process: 1. Address information is only collected for head of household 2. Timeliness of notifications 3. Difficult or impossible to locate/contact clients who have moved or changed telephone numbers 4. Client and staff side human error
Notes: TRAILS clients are also issued a Medical ID Card on new clients. They generate a daily file and put the file on the server for CBMS to pick up and merge with the Medical ID Card Request file of CBMS clients.

Perform Population and Member Outreach – ME03

CO MITA 3.0 SS-A Project

Business Area: Member Management (ME) - Under Development
Business Category: Member Support (Future Release)
Business Process: Perform Population and Member Outreach
Author(s): Joey Gallegos, Brian Knight, Leah Jardine, Jerry Smallwood, Brad Shipley, Jeff Helm, Rachel Reiter, Collen Daywalt
Facilitator: Nicole Wong
Actor(s): Clients, Prospective Clients, State Staff, Outreach Contractor, Training Contractor, Providers, Eligibility Workers, Nationwide Data Contractor, Enrollment Vendor/Broker, Utilization Management Vendor, Healthy Communities Family Health Coordinators
MITA 3.0 Business Process Description: **NOTE**: Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Eligibility & Enrollment (Member), the Member Management business processes or business capability matrices, and a portion of the Concept of Operations (COO) outlining the "to-be" for eligibility, enrollment, and insurance exchange information. CMS will update the MITA 3.0 Framework with appropriate information from the final rules. ***MITA 2.0 Business Process Description:*** The **Perform Population and Member Outreach** business process targets both prospective and current recipient populations for distribution of information about programs, policies, and health issues. Inquiries from applicants, prospective and current recipients are handled by the **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area) by providing assistance and responses to individuals. ***CO Business Process Description:*** Colorado's **Perform Population and Member Outreach** process is generally aligned with the MITA 2.0 Framework. Examples of Outreach activities are: • New benefit packages and population health initiatives • New initiatives from Program Administration • Information/Training to clients on new programs • Medicaid program education • Information on other programs that may be available to a client (i.e. EPSDT and/or CHP+) • Availability of a Healthy Communities Family Health Coordinator for clients who are EPSDT eligible (age 0 – 20), and children and pregnant women on CHP+

- Changes to health plan enrollment
- Changes to client eligibility

Precondition:

- Citizens of Colorado who may be informed or uninformed on Medicaid or CHP+

Trigger(s):

1. Client assessed as having a need for a specific service
2. Client eligibility expansion initiatives
3. Health initiatives/promotions
4. Policy changes
5. Process improvement
6. Problem identified with current process
7. Benefit expansion initiatives
8. Health promotion to existing population
9. No Wrong Door, i.e. Health Insurance Exchange
10. Changes to health plan options and enrollment

Manual (M) or Automated (A)		***Steps:***
		Individual Client Specific:
1.	M	**START**: Determine client need
2.	M	**Inform** client about services and how they match their need
3.	M	**END**: **Provide** information about delivery of services
		Group Clients Specific:
1.	M	**START**: **Obtain** information from subject matter experts
2.	M	**Obtain** stakeholder input
3.	M	Target areas/groups are **identified** by need, geography, financials, etc.
4.	M	**Determine** resources available
5.	M	**Determine** most effective way to provide information
6.	M	**Generate** outreach list from DSS, if applicable
7.	M	**END**: **Provide** the information
		Prospective Clients:
1.	M	**START**: Obtain information from subject matter experts
2.	M	**Obtain** stakeholder input
3.	M	Target areas/groups are **identified** by need, geography, financials, etc.
4.	M	**Determine** current barriers for enrollment
5.	M	**Determine** resources available
6.	M	**Determine** most effective way to provide information
7.	M	**Determine** area of state with high eligible, but not enrolled, population
8.	M	**END**: **Provide** the information about the enrollment process and covered

		benefits and services

Outcome:
1. Increased enrollment
2. Increased appropriate benefit utilization
3. Improved health outcomes
4. Improved health literacy and empowerment
5. Improved client engagement

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Reduced call volume to Medicaid Customer Contact Center regarding trigger addressed by communication
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS 3. CBMS 4. Email 5. Face-to-face meetings 6. Mail 7. Connect for Health Colorado 8. Partner agencies (DHS, OIT, CDPHE, DORA/DOI) 9. Calls to Medicaid Customer Contact Center 10. Contractors (HealthColorado, Maximus, RCCOs) 11. Media 12. Website/social media 13. CMS	***Shared Data/Interfaces, Outbound***: 1. Email 2. Face-to-face meeting 3. Mail 4. Website/ social media 5. Medicaid Customer Contact Center 6. Contractors (Health*Colorado*, Maximus, RCCOs) 7. Media 8. CMS

To Be Future Vision:
1. Sort by a variety of variables in the DSS
2. Improved reporting capabilities in the DSS
3. Targeted and appropriate communications with clients
4. Update client information through Report My Changes function in Colorado.gov/PEAK client contact information so client communications can be successfully completed
5. Make clients aware that they can update and review their information online via PEAK
6. e-Noticing and e-blasts that allow direct communication with clients via email or text message
7. Interface with Medicaid Customer Contact Center client database and Health Communities case worker's databases

8. Creation of client correspondence review process
Failures of the Current Process: 1. Inability to identify the right clients (have bad contact information); difficult or impossible to locate/contact clients who have moved or changed telephone numbers 2. Inability to address population health - identification of sub-groups 3. Lack of cultural competency and resources to support translation services 4. The ability to measure the success of our efforts, or lack thereof 5. Lack of resources to produce client-geared geared resources about enrollment and benefits 6. Lack of real-time or direct client communication avenues 7. Lack of community outreach resources for the adult Medicaid population to mirror state's Family Health Coordinators program for children 8. Lack of client correspondence review process and standardization 9. Lack of resources to conduct client testing and message testing
Notes:

Manage Member Grievance and Appeal – ME08

CO MITA 3.0 SS-A Project

Business Area: Member Management (ME) - Under Development
Business Category: Member Support (Future Release)
Business Process: Manage Member Grievance and Appeal
Author(s): Joey Gallegos, Brian Knight, Leah Jardine, Jerry Smallwood, Brad Shipley, Vicki Foreman, Robert Lodge, Alan Kishowitz
Other Attendance (non-participating): Jennifer Jordan (SD/HP – phone), Mark Shaffer (SD/HP), Karl Schnur (SD/HP – phone)
Facilitator: Nicole Wong
Actor(s): Department Staff, Office of Appeals Staff, Client or their Advocate, Case Managers, Contractors (including Fiscal Agent), Providers, Counties
MITA 3.0 Business Process Description: **NOTE**: Due to the regulation rule-making efforts underway at CMS, the MITA Framework 3.0 does not include the Eligibility & Enrollment (Member), the Member Management business processes or business capability matrices, and a portion of the Concept of Operations (COO) outlining the "to-be" for eligibility, enrollment, and insurance exchange information. CMS will update the MITA 3.0 Framework with appropriate information from the final rules. ***MITA 2.0 Business Process Description:*** The **Manage Member Grievance and Appeal** business process handles applicant or recipient (or their advocate's) appeals of adverse decisions or communications of a grievance. The **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area) via the **Receive Inbound Transaction** process receives a grievance or appeal. The grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; a hearing may be scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or recipient and stored in the applicant or recipient information file. The applicant or recipient is formally notified of the decision via the **Send Outbound Transaction Process**. This process supports the **Program Quality Management** business area (In MITA 3.0 it is the **Performance 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. In some states, if the applicant or recipient does not agree with the Agency's disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or recipient is urgent, the appeal may be expedited.

NOTE: States may define "grievance" and "appeal" differently, perhaps because of state laws. States must enforce the Balanced Budget Act requirements for grievance and appeals processes in their MCO contracts at 42 CFR Part 438.400. They may adopt these for non-MCO programs.

CO Business Process Description:
Colorado's **Manage Member Grievance and Appeal** business process is generally aligned with the MITA 2.0 Framework.

Precondition:

- Adverse action occurs
- Notice of action is sent to client with appeal rights
- Client or applicant has filed an application or intent to file an application has been determined
- A client's benefits and services are denied, reduced or changed

***Trigger(s)*:**

1. Client files an informal resolution dispute with the Counties
2. Client or applicant files a written appeal with the OAC
3. Client or applicant verbalizes the intent to file a grievance to appropriate agencies

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** written or verbal notification of appeal.
		Eligibility
2.	M	Client has the opportunity to do an **informal dispute resolution** with the Counties. If yes, skip to step 4.
		Managed Care Organizations
2.	M	In-house **informal appeal process** and **renders** a decision, and Client has the opportunity to submit a grievance with the MCO. If yes, skip to step 4.
		CHP+
2.	M	Client can **informally appeal** with CHP+ ASO
3.	M	Client can **appeal** the grievance decision with the State. If yes, continue to step 4.
4.	M	**Submit** formal appeal to Office of Administrative Courts
5.	M	Office of Administrative Courts **notifies** the Office of Appeals regarding formal appeal

6.	M	Office of Appeals **tracks** and **distributes** appeal to appropriate policy staff
7.	M	Assigned policy staff or designee **tracks**, **researches**, **participates** and **files** paperwork and attends hearings as necessary
8.	M	If Policy staff or designee **determines** it is a necessary case to go to appeal then an appeal is **held** at the Office of Administrative courts
9.	M	The Office of Administrative courts **issue** on an initial decision
10.	M	If the parties do not agree with the initial decision, a **reconsideration** can take place
11.	M	If the parties agree with the initial decision, **Receive** Final Agency Decision (FAD)
12.	M	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. c. Appropriate actions are taken by the eligibility workers
13.	M	**END**: Eligibility is **re-run** or system is **refreshed**. Appropriate action is taken in accordance with the final agency decision.

***Outcome*:**

1. Grievance and appeal process has been completed for HCPF

As Is Performance Metrics:	***To Be Performance Metrics:***
• Time to complete process = 90 calendar days ***Supporting Performance Metrics/SLA Documentation:*** • 42 CFR, Section 431.221 (d)	• Time to complete process = 90 calendar days
Shared Data/Interfaces, Inbound: 1. CBMS 2. Contractors (including Fiscal Agent) 3. MMIS 4. BUS 5. Access database 6. Excel spreadsheets 7. APS 8. Email 9. Clinical Information from physicians and clients 10. Client information 11. PDCS	***Shared Data/Interfaces, Outbound*:** 1. APS 2. Notice of Action 3. Transmittal to Fiscal Agent 4. MMIS 5. Notice from Fiscal Agent to vendor 6. PDCS

To Be Future Vision:

Manage Member Grievance and Appeal – ME08

1. One Prior Authorization reviewing agency
2. Centralized repository for all agencies/departments to utilize
3. Automate appeal notices
4. Electronic appeals submission
5. Electronic notification of appeals and appeal rights
6. Standardization of communication to reduce confusion that causes appeals
7. Multi-language capability
8. Multi-grade level capability
9. 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
10. Development of educational materials for clients about the process in general

Failures of the Current Process:

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

Notes:

Client receives benefits while an appeal is in process. If the client loses the appeal, the client owes the benefits paid during the appeals process.

The client appeals process has gone through a LEAN process on overall improvement.

7 – Operations Management Use Cases

Submit Electronic Attachment – OM04

CO MITA 3.0 SS-A Project

Business Area: Operations Management
Business Category: Claims Adjudication
Business Process: Submit Electronic Attachment
Author(s): Joey Gallegos, Brian Knight, Leah Jardine, Jerry Smallwood, Brad Shipley, Vicki Foreman, Robert Lodge, Alan Kishowitz, Vernae Roquemore
Other Attendance (non-participating): Mark Shaffer (SD/HP), Karl Schnur (SD/HP – phone), Jennifer Jordan (SD/HP – phone)
Facilitator: Nicole Wong
Actor(s): Reviewing Agencies (Fiscal Agent, Contractors), Department Staff, County Staff, Providers, Clients
MITA 3.0 Business Process Description: The **Submit Electronic Attachment** business process begins with receiving attachment information that either a payer requests (solicited) or a provider submits (unsolicited). The solicited attachment information can be in response to requests for more information from the following business processes for example: **Process Claim (OM07)** (part of the Operations Management business area), **Process Encounter (OM29)** (part of the Operations Management business area), **Authorize Service (OM08)** (part of the Care Management business area), **Authorize Treatment Plan (CM09)** (part of the Care Management business area), and **Manage Estate Recovery (FM03)** (part of the Financial Management business area). The business process links attachment information to the associated applicable transaction (e.g., claim, prior authorization, treatment plan) or suspends for a predetermined time set by state specific business rules, after which the business process purges information. The business process validates the successfully associated attachment information using application-level edits, determining whether the information provides the additional information necessary to adjudicate (i.e., approve, suspend or deny) the transaction. ***CO Business Process Description:*** Colorado's **Submit Electronic Attachment** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Services requiring attachments are needed, PARS (drugs, DME supplies)
Trigger(s): 1. Authorization is submitted to reviewing agency 2. Claim/Authorization is submitted to Fiscal Agent/MMIS

Manual (M) or Automated (A)	***Steps:***

1.	M	**START**: Reviewing Agency or Department staff **receives** claim/authorization
2.	M	Reviewing Agency or Department staff **reviews** Claim/authorization attachment for completion
3.	M	Reviewing Agency or Department staff **verify** attachment is appropriate for claim/authorization a. PAR is approved, pended or denied b. Claim is paid or denied (including reconsiderations)
4.	M	**END**: Attachment is **archived** after the decision is made

Outcome:
1. Claim/authorization is finalized
2. Services are either approved or not approved

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. Docfinity (scanning database) 2. BUS 3. CCMS 4. Web Portal (does not hold the attachment) 5. MMIS (does not hold the attachment) 6. DSS (does not hold the attachment)	***Shared Data/Interfaces, Outbound***: 1.

To Be Future Vision:
1. Attachments are stored in the DSS
2. Attachments are stored in the MMIS
3. Attachments are linked to the claims/authorizations
4. Electronic Health Record interface
5. More accessible attachment data to monitor appropriateness of services provided
6. Attachments are searchable via current mechanisms (e.g. character recognition software)

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

Notes:

Apply Mass Adjustment – OM05

CO MITA 3.0 SS-A Project

Business Area: Operations Management
Business Category: Claims Adjudication
Business Process: Apply Mass Adjustment
Author(s): Jim Becker, Joan Welch, Robert Lodge, Nellie Pon, Alan Kishowitz
Other Attendance (non-participating): Karl Schnur
Facilitator: Nicole Wong
Actor(s): Department Staff, Fiscal Agent, Providers, Legislature, CMS
MITA 3.0 Business Process Description: The **Apply Mass Adjustment** business process begins with the receipt or notification of retroactive modifications. These changes may consist of modified rates associated with Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment by identifiers (e.g., claim/bill type, HCPCS, CPT, Revenue Code(s), or member identification) that the State Medicaid Agency (SMA) paid incorrectly during a specified date range. The business process applies a predetermined set or sets of parameters that may reverse or amend the paid or denied transactions and repay correctly. **NOTE**: Do not confuse this process with the claim adjustment within the adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, mass adjustments historically refer to large-scale modifications in payments as opposed to disenrollment of a group of members from a Managed Care Organization (MCO). ***CO Business Process Description:*** Colorado's **Apply Mass Adjustment** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Claims have been adjudicated (in paid, to be paid, denied, or to-be denied status)
Trigger(s): 1. Rate adjustments 2. Legislation 3. Policy changes 4. Transmittals 5. Identification of payment errors and accounting errors 6. Identification of payment recovery from Program Integrity review

7. CMS Approval		
Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Department or fiscal agent staff **identifies** claims/criteria for adjustment
2.	M	Department staff **submits** a request for adjustment to the fiscal agent
3.	A	Fiscal Agent **performs** MMIS/PDCS mass adjustment
4.	M/A	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.	A	**Process** claims according to transmittal instructions or standard processing rules
6.	M/A	**END**: **Finalize** claims

Outcome:
1. Claims have been mass adjusted

As Is Performance Metrics:	***To Be Performance Metrics:***
• MMIS SLAs ***Supporting Performance Metrics/SLA Documentation:*** • MMIS SLAs	• MMIS SLAs
Shared Data/Interfaces, Inbound: 1. MMIS 2. TrackWise 3. DSS 4. COLD 5. Web Portal 6. COFRS/CORE 7. PDCS 8. CBMS 9. DORA	***Shared Data/Interfaces, Outbound***: 1. Provider Claims Report 2. 835 Electronic Remittance Advice 3. COFRS/CORE 4. DSS 5. TrackWise 6. APCD 7. MMIS 8. PDCS

To Be Future Vision:
1. Allow more complex, pre-defined and unlimited match criteria
2. Ability to mass adjust encounters and capitations
3. Ability to apply partial recoveries to claims
4. Flexible notification of history-only processing
5. Automated process to take most recent chain in DSS
6. 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 of the Current Process:
• If mass adjustments have not been applied timely, edits application becomes more and more manual • Lack of timeliness of notifications of rate/code changes • Required legislative and CMS approvals result in delays of rate updates, thereby causing mass adjustments • 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) • Current MMIS cannot compare allowed amount of adjusted claim to the allowed amount of the original claim
Notes:

Process Claim – OM07

CO MITA 3.0 SS-A Project

Business Area: Operations Management
Business Category: Claims Adjudication
Business Process: Process Claim
Author(s): Jim Becker, Karl Schnur, Jean Welch, Robert Lodge, Nellie Pon, Alan Kishowitz, Vernae Roquemore, Carol Reinboldt
Facilitator: Nicole Wong
Actor(s): Fiscal Agent, Web Portal, State staff, providers, DSS, MMIS, TPMS

MITA 3.0 Business Process Description:

The **Process Claim** business process receives original or adjusted claim (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction, assigns an internal control number, and

- Determines its submission status, and based on that:
  - Performs Claims Edits:
    - ✓ Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction.
    - ✓ Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding.
  - Performs Claims Audits:
    - ✓ Verify against historical information.
    - ✓ Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity.
  - Suspends claim that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules.
  - Applies National Correct Coding Initiative (NCCI) Edits.
  - Applies Diagnosis Related Group (DRG)/Ambulatory Payment Classification
  - (APC), as appropriate.
  - Prices Claims:
    - ✓ Calculate state allowed amount.
    - ✓ Calculate paid amount.

NOTE: All fee-for-services claim types will go through most of the business process steps but with different business rules associated with the different claim types. Both Centers for Medicare & Medicaid Services (CMS) and state policy determine business rules for claims edits, audits, and pricing methodologies. State business rules define whether the State Medicaid Agency (SMA) pays, suspends, flags for information, or denies a claim. State business rules define whether an edit is fatal or non-fatal as well. See Constraints.

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

NOTE: This business process is part of a suite including **Calculate Spend-down Amount (OM20)** (part of the Operations Management business area), **Submit Electronic Attachment (OM04)** (part of the Operations Management business area), and **Generate Remittance Advice business processes (OM14)** (part of the Operations Management business area).

CO Business Process Description:
Colorado's **Process Claim** business process is generally aligned with that described in the MITA 3.0 Framework. Ambulatory Payment Classification (APC) and grouper for Ambulatory Surgical Centers (ACS) do not apply to Colorado claims processing.

Precondition:

- Service claims have been submitted
- Service claims need to be reimbursed
- Claim accepted for processing
- Rules around submitting a claim have been established
- Rates are set
- Client is enrolled
- Provider is enrolled
- Adjudication data is loaded and available
- Prior authorizations are in place
- Edits and edit dispositions are defined
- Manual resolution procedures are defined
- Client copay requirements / applicability defined
- Business rules are in place for specific programs

Trigger(s):

1. Claim is submitted
2. Capitation cycle
3. Receipt of transmittals (to adjust claims)

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receipt** of request. Claims can be received electronically or paper (Mostly automated)
2.	M/A	**Validate** minimum required information is present for claim to be entered into the system
3.	M/A	**Review** and **validate** appropriate claim information is present and ready for pricing

4.	M/A	**Edit** the claim a. If necessary, perform data corrections b. Perform business edits as necessary to match valid claim criteria (e.g., service submitted on the claim matches policy rules, provider type, authorizations, etc.)
5.	M/A a. A b. A c. A d. M	**Price** the claim 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.)
6.	M/A a. M/A b. A c. A	**Audit** the claim a. Check for duplicate processed claims b. Apply benefit limitations if applicable c. Check for contraindications
7.	A	**Conduct** final pricing activities for the claim. The MMIS **adjusts** the payment/pricing for: a. Client co-payments b. Third Party Liability and Medicare payments c. Client payments d. Apply prior authorization and other cut back pricing e. Deduct any applicable accounts receivable amounts (due to the financial cycle)
8.	A	**END:** Claim adjudication results are **recorded**

***Outcome*:**

1. Claim is adjudicated, audited and priced appropriately
2. Processing results are recorded and ready for distribution as necessary

As Is Performance Metrics:	***To Be Performance Metrics:***
• MMIS SLAs ***Supporting Performance Metrics/SLA Documentation:*** • MMIS SLAs	• MMIS SLAs
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS 3. COFRS 4. CBMS 5. DORA 6. PDCS	***Shared Data/Interfaces, Outbound*:** 1. Provider Claims Report 2. 835 Electronic Remittance Advice 3. COFRS/CORE 4. DSS

7. COLD 8. Web Portal 9. Flat files for PAR 10. 278U 11. COBC	5. TrackWise 6. APCD 7. MMIS 8. PDCS

To Be Future Vision:

1. Ability to assign as many provider types to a claim as necessary; flexibility to add at will
2. Flexibility for users to define fields (for reporting, payment adjudication, etc.) with minimal cost and time
3. Ability to implement user-defined adjudication rules (e.g., to specific populations groups)
4. Electronic attachments
5. Ability to feed information into new DSS that has same type of flexibility as the new MMIS
6. Cooperative relationship between Fiscal Agent and State to implement changes to the system and/or business rules
7. Ability to implement changes quickly
8. Reduce need for operational manual work-around
9. 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.)
10. Capture client eligibility information applicable at adjudication
11. 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
12. Automate multiple surgery pricing
13. More logic for procedural code modifiers to bypass manual processes
14. Implement an outpatient grouper payment methodology (e.g. EAPG)

Failures of the Current Process:

1. MMIS does not allow different users to assign different benefits
2. Inflexibility of hard-coded claims adjudication rules creates issues
3. Cost and time of changing anything (in either of the systems) adjudication rules; CSR back-log
4. Lack of FTEs to make adjudication rules changes
5. Manual work-around required due to system inflexibility and CSR back-log
6. Limited ability to determine pricing mechanism and/or original rate applied to claim
7. 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:

Process Claim – OM07

Generate Remittance Advice – OM14

CO MITA 3.0 SS-A Project

Business Area: Operations Management		
Business Category: Payment and Reporting		
Business Process: Generate Remittance Advice		
Author(s): Dawn McGlasson, Jim Berker, Tim Gaub, Joan Welch, Vernae Roquemore, Carol Reinboldt		
Other Attendance (non-participating): Karl Schnur (SD)		
Facilitator: Nicole Wong		
Actor(s): Fiscal Agent, CS&O, Controllers Division, Program staff, Providers		
MITA 3.0 Business Process Description: The **Generate Remittance Advice** business process describes the activity of preparing remittance advice/encounter Electronic Data Interchange (EDI) transactions that providers use to reconcile their accounts receivables. This business process begins with receipt of information resulting from the **Process Claim (OM07)** business process (part of the Operations Management business area), performing required manipulation according to business rules and formatting the results into the required output information that process sends to **Send Outbound Transaction**. ***CO Business Process Description:*** Colorado's **Generate Remittance Advice Report** business process is generally aligned with that described in the MITA 3.0 Framework. In Colorado, encounter data does not go through financial processing in the MMIS. In addition, no remittance report is generated for encounter data in Colorado.		
Precondition: • Submitted claims, transmittals (i.e. financial, suspension of service, mass adjustments)		
Trigger(s): 1. Provider submits claims 2. Financial cycle process (occurs weekly on Friday night)		
Manual (M) or Automated (A)		***Steps:***
1.	A	**START**: **Run** claim validation preprocess for syntax errors a. Accept b. Reject
2.	A	**Load** accepted claim into MMIS
3.	A	MMIS **reviews** and edits claim

4.	A	MMIS **adjudicates** claim
5.	A	Claims **roll** into financial cycle
6.	M/A	**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*:**
1. RA Reports are prepared.

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. MMIS 2. File Report Service (FRS) (Web Portal) 3. COLD (Computer Output Laser Disk) 4. DSS 5. COFRS/CORE	***Shared Data/Interfaces, Outbound*:** 1. Web Portal 2. COLD (Computer Output Laser Disk) 3. DSS 4. MMIS 5. COFRS/CORE

To Be Future Vision:
1. Reduce Paper usage
2. Be NPI based rather than State Provider ID (pay and report)
3. Expand DSS to include suspended claims
4. Majority of reporting is done in the DSS (not from production environment)
5. New DSS to include all information in MMIS
6. New DSS to be updated more frequently to allow more frequent reporting
7. Clean user interface for the provider web portal
8. Improve knowledge transfer

Failures of the Current Process:
1. Inflexible report (proprietary report does not contain enough detail and cannot be updated without a CSR)
2. All information necessary to generate report not included in DSS
3. If COFRS has any liens or holds (could be unrelated to healthcare payment), payment could be held back

Notes:

Generate Remittance Advice – OM14

CO MITA 3.0 SS-A Project

Business Area: Operations Management

Business Category: Payment and Reporting

Business Process: Inquire Payment Status

Author(s): Dawn McGlasson, Jim Berker, Tim Gaub, Joan Welch, Vernae Roquemore, Carol Reinboldt

Other Attendance (non-participating): Karl Schnur (SD)

Facilitator: Nicole Wong

Actor(s): Providers, Data Staff, CS&O Staff, Accounting, Fiscal Agent, External Data Request Board, Auditors, Contract Managers, Client

MITA 3.0 Business Process Description:

The **Inquire Payment Status** business process begins with receiving an Accredited Standards Committee (ASC) X12 276 Health Care Claim Status Request transaction or a request for information received through other means such as email, paper, telephone, facsimile, web, or Automated Voice Response (AVR). The business process handles the request for the status of a specified claim(s), retrieves information from the claims payment history, and generates the response information. In addition, the business process formats the information into the ASC X12 277 Health Care Information Status Notification transaction, or other mechanism for responding, via the media used to communicate the inquiry, and sends claim status response via the **Send Outbound Transaction**.

CO Business Process Description:

Colorado's **Inquire Payment Status** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- Requirement for Claim Information:
  - Services Provided
  - Claim Received

Trigger(s):

1. Request for information

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: Inquiry **received**
2.	M/A	Inquiry is **authenticated** and **approved** (as appropriate)
3.	M/A	Inquiry is **routed**
4.	M/A	Inquiry is **processed** (as appropriate)
5.	M/A	**END**: Response is **communicated**

Outcome:

<table>
<tr><td colspan="2">1. Response to inquiry provided</td></tr>
<tr><td>As Is Performance Metrics:
• N/A

Supporting Performance Metrics/SLA Documentation:
• N/A</td><td>To Be Performance Metrics:
• N/A</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. MMIS
2. DSS
3. Web Portal
4. AVR
5. COLD
6. COFRS/CORE
7. SDAC
8. Telephone
9. Email</td><td>Shared Data/Interfaces, Outbound:
1. Web Portal
2. AVR
3. MMIS
4. Telephone
5. Email</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. New DSS
2. Improved reporting
3. Improved information sharing between MMIS and COFRS/CORE
a. Indicate offsets via notifications between systems
b. Associate EFT/warrant numbers with specific claims in MMIS
4. Contractor-specific data access (controllable by roles/permissions)
5. Improved information sharing with Providers</td></tr>
<tr><td colspan="2">Failures of the Current Process:
1. Contractor requires State staff to process data access/reporting needs
2. Transactional failures between MMIS and Web Portal (X12 interface / service processing)
3. Reconciliation between MMIS and COFRS/CORE</td></tr>
<tr><td colspan="2">Notes:</td></tr>
</table>

Prepare Provider Payment – OM27

CO MITA 3.0 SS-A Project

Business Area: Operations Management
Business Category: Payment and Reporting
Business Process: Prepare Provider Payment
Author(s): Bailey Perkins, Sandy Salus, Tim Gaub, Vernae Roquemore, Carol Reinboldt
Other Attendance (non-participating): Karl Schnur, Mark Schaffer
Facilitator: Nicole Wong
Actor(s): Fiscal Agent, Providers, Clients, Department Staff, Other State Agencies
MITA 3.0 Business Process Description: The **Prepare Provider Payment** business process is responsible for the preparation of the payment report information. Reports sent via email, mail, or Electronic Data Interchange (EDI) to providers and used to reconcile their accounts receivable. Many Home and Community-Based Services (HCBS) are not part of the traditional Medicaid health plan. Services tend to be member specific and often arranged through a plan of care. Atypical providers who render services for HCBS waivers may not have authorization, or may not adjudicate in the same manner as other health care providers. This business process begins with receipt of HCBS information from the **Process Claim (OM07)** business process (part of the Operations Management business area) or capitation information from **Process Encounter (OM29)** business process (part of the Operations Management business area), performing required manipulation according to business rules, and formatting the results into the required information. The capitation payment activity includes a per-member-per-month payment for Managed Care Organizations (MCO), Primary Care Case Managers (PCCM), and other capitated programs. This business process begins with a timetable for scheduled correspondence stipulated by Trading Partner Agreement (TPA) and includes retrieving enrollment and benefit transaction information from the Member data store, retrieving the rate information associated with the plan from the Provider or Contractor data store, and formatting the payment into the required information. ***CO Business Process Description:*** Colorado's **Prepare Provider Payment** business process generally aligns with MITA 3.0.
Precondition: • **Process Claim (OM07)** business process (part of the Operations Management business area) • **Process Encounter (OM29)** business process (part of the Operations Management

business area)

Trigger(s):

1. MMIS processes the claim and sends the positive payments interface to COFRS/CORE for payment. (**Process Claim (OM07)** business process (part of the Operations Management business area)).
2. Monthly trigger through MMIS to COFRS/CORE to pay the capitation payment /encounter capitation to the managed care organization. (**Process Encounter (OM29)** business process (part of the Operations Management business area)).

Manual (M) or Automated (A)		***Steps:***
1.		**Fee for Service, Managed Care Payment**
2.	A	**START**: **Receive** trigger from **Process Claim (OM07)** business process (part of the Operations Management business area)
3.	M/A	**Calculate** payment amount
4.	A	**Generate** payment report
5.	A	Interface file **sent** to COFRS/CORE for EFT payment or issuing of a warrant
6.	A	COFRS/CORE **sends** a file back with EFT or warrant information after payment has been issued
7.	M/A	**END**: **Send** payment information to member or provider
		Capitation Payment
1.	A	**START**: Periodic timetable is **due** for capitation payment
2.	A	**Calculate** payment amount
3.	A	**Generate** payment report
4.	M/A	**END**: **Send** alert to submit capitation payment information to member

Outcome:

1. Generated provider's payment report
2. Alert to send payment information to member or provider, where applicable
3. Alert to send capitation payment information to member
4. Tracking information as needed for measuring performance and business activity monitoring. Tracking information for diagnosis, i.e. geographical area information such as disease management.

As-Is Performance Metrics:	***To-Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS	***Shared Data/Interfaces, Outbound***: 1. MMIS

3. PDCS 4. BUS 5. CBMS 6. COFRS/CORE	2. PDCS 3. BUS 4. CBMS 5. COFRS/CORE
To Be Future Vision: 1. Continue the current amount of automation that is already in place	
Failures of the Current Process: 1. System failure of **Process Claim (OM07)** or **Process Encounter (OM29)** business processes (part of the Operations Management business area). (This is a rare occurrence but could take place).	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Operations Management

Business Category: Payment and Reporting

Business Process: Manage Data

Author(s): Vicki Foreman, Nathan Culkin, Rene Horton, Vernae Roquemore, Carol Reinboldt

Facilitator: Nicole Wong

Actor(s): Department Staff, Fiscal Agent, Contractors, Centers for Medicare & Medicaid Services (CMS), Other State Agency Staff

MITA 3.0 Business Process Description:

The **Manage Data** business process is responsible for the preparation of the data sets and delivery to federal agencies (e.g., Centers for Medicare & Medicaid Services (CMS), Social Security Administration (SSA). Information exchange may include extraction of Medicaid and CHIP Business Information and Solutions (MACBIS) information needs (i.e., fee-for-services, managed care, eligibility and provider information).

The **Manage Data** business process includes activity to extract the information, transform to the required format, encrypt for security, and load the electronic file to the target destination.

The uses for the information include:

- Research and evaluation of health care activities.
- Staff can forecast the utilization and expenditures for a program.
- Staff can analyze policy alternatives.
- State and federal agencies can respond to congressional inquiries.
- Matches to other health related databases.

CO Business Process Description:

Colorado's **Manage Data** business process generally aligns with the MITA 3.0 Framework.

Precondition:

NOTE: Many MITA Framework business processes collect data for extraction of information and send to target destination. The following are the business processes that manage primary data stores.

- **Manage Case Information (CM02)** business process (part of the Care Management business area)
- **Manage Contractor Information (CO02)** business process (part of the Contractor Management business area)
- **Manage Member Information (ME01)** business process (part of the Member

Management business area)

- **Manage Provider Information (PM01)** business process (part of the Provider Management business area)
- **Manage Budget Information (FM17)** business process (part of the Financial Management business area)
- **Manage Accounts Receivable Information (FM06)** business process (part of the Financial Management business area)
- **Manage Accounts Payable Information (FM13)** business process (part of the Financial Management business area)
- **Generate Financial Report (FM19)** business process (part of the Financial Management business area)
- **Process Claim (OM07)** business process (part of the Operations Management business area)
- **Process Encounter (OM29)** business process (part of the Operations Management business area)
- **Generate Remittance Advice (OM14)** business process (part of the Operations Management business area)
- **Manage Compliance Incident Information (PE03)** business process (part of the Performance Management business area)
- **Maintain State Plan (PL03)** business process (part of the Plan Management business area)
- **Manage Health Plan Information (PL04)** business process (part of the Plan Management business area)
- **Manage Health Benefit Information (PL06)** business process (part of the Plan Management business area)
- **Manage Performance Measures (PL05)** business process (part of the Plan Management business area)
- **Manage Reference Information (PL07)** business process (part of the Plan Management business area)

***Trigger(s)*:**

1. Periodic (e.g., quarterly) timetable for information is due
2. Receive request for information

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** time event or request to initiate the **Manage Data** business process
2.	M/A	**Extract** required information from source data stores
3.	M/A	**Transform** information to meet business and technical needs of target destination
4.	M/A	**Apply** necessary encryption algorithms for security
5.	M	**END**: **Send** message with information to the target destination

Manage Data – OM28

<table>
<tr><td colspan="2">Outcome:
1. Information message sent to target destination
2. Tracking information as needed for measuring performance and business activity monitoring</td></tr>
<tr><td>As Is Performance Metrics:
• MSIS: Quarterly
• PERM: Every three (3) years
• CMS 37 & 64: Quarterly
• EPSDT 416: Annually
• Waiver reporting: Quarterly and annually
• MMA (CBMS generated) monthly

Supporting Performance Metrics/SLA Documentation:
• MARS System Documentation</td><td>To Be Performance Metrics:
• Track timeliness of report delivery</td></tr>
<tr><td>Shared Data/Interfaces, Inbound
1. MMIS
2. BUS
3. Department Web Site for State Plan, health plan, health benefits
4. MMIS System Documents reference data
5. ESURS
6. Contractor data stores
CBMS
7. DORA
8. Contract Management System (CMS)
9. COFRS/CORE</td><td>Shared Data/Interfaces, Outbound:
1. PDCS
2. All outbound federal reports
3. Contractor data store (e.g. SDAC)
4. CMS (federal) interface
5. Reports to providers
6. CBMS</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. TMSIS
2. The BUS will be integrated into MMIS
3. The MMIS system documentation and reference data will be incorporated into MMIS
4. SDAC will be integrates with DSS to make BIDM and all reports are generated out of BIDM
5. Increased automation and report generation in real time
6. Increase bidirectional communication between all systems</td></tr>
<tr><td colspan="2">Failures of the Current Process:
1. Requested information is not available for extraction
2. Transformation does not meet the federal requirements for submission
3. Information message does not meet the target destination submission requirements
4. Not enough automation, manual intensive</td></tr>
<tr><td colspan="2">Notes:</td></tr>
</table>

Manage Data – OM28

Process Encounter – OM29

CO MITA 3.0 SS-A Project

Business Area: Operations Management
Business Category: Claims Adjudication
Business Process: Process Encounter
Author(s): Vicki Foreman, Nathan Culkin, Rene Horton
Facilitator: Nicole Wong
Actor(s): Fiscal Agent, Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), Department Staff, Health Service Advisory Group (HSAG), TREO, Other Contractors

MITA 3.0 Business Process Description:

The **Process Encounter** business process receives original or adjusted encounter (e.g., institutional, professional, dental, pharmacy, and waiver) information via web or Electronic Data Interchange (EDI) transaction and determines its submission status, and based on that:

- Performs Encounter Edits:
  - Edit a single transaction for valid syntax and format, identifiers and codes, dates, and other information required for the transaction.
  - Validate business edits, service coverage, Third-Party Liability (TPL), and reference coding.

- Performs Encounter Audits:
  - Verify against historical information.
  - Verify that services requiring authorization have approval, clinical appropriateness, and payment integrity.

- Suspends encounter that fail edits or audits for return to the provider for corrections, additional information, or internal review according to state defined business rules.
  - Apply National Correct Coding Initiative (NCCI) Edits.
  - Apply Diagnosis Related Group (DRG)/Ambulatory Payment Classification (APC), as appropriate.
  - Prices Encounters:
    - ✓ Calculate state allowed amount.
    - ✓ Calculate paid amount.
    - ✓ Set paid amount to zero dollars.

NOTE: All encounters will go through most of the business process steps but with different business rules associated with the different encounter claim types. Both Centers for Medicare & Medicaid Services (CMS) and state policy determine business rules for encounter edits, audits, and pricing methodologies. State business rules define whether an encounter goes to a to-be-paid status, suspends, flags for information, or denies. State

business rules define whether an edit is fatal or non- fatal as well. See Constraints.

NOTE: An adjustment to an encounter is on an exception use case to this business process that follows the same process path except it requires a link to the previously submitted processed encounter in order to reverse the original encounter and associate the original and replacement encounter in the calculation information.

NOTE: This business process is part of a suite including **Calculate Spend-down Amount (OM20)** (part of the Operations Management business area), **Submit Electronic Attachment (OM04)** (part of the Operations Management business area), and **Generate Financial Report (FM19)** business processes (part of the Financial Management business area).

CO Business Process Description:
Colorado's **Process Encounter** business process is generally aligned with the MITA 3.0 Framework. However, NCCI edits and dental encounters do not apply to this process. Colorado does not calculate spend down in this process.

Precondition:

- Rules around submitting encounters have been established
- Rate is set
- Client is enrolled
- Adjudication data is loaded and available
- Edits and edits dispositions are defined
- Client copay requirements / applicability defined

***Trigger(s)*:**

1. Service encounters have been submitted
2. Encounters accepted for processing
3. Receive Inbound Transaction

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receipt** of inbound transaction (x12/BHO MCO flat file)
2.	A	**Validate** minimum required information is present for encounter to be entered into the system
3.	M/A	**Edit** the encounter 1. If necessary, edit data provided on the encounter to match valid system data (e.g., client and provider and other data) 2. Perform business edits as necessary to matches valid encounter criteria (e.g., service submitted on the encounter)
4.	M/A	**Review** and **validate** appropriate encounter information is present and ready for pricing
5.	M/A 1. A	**Price** the encounter according to the pricing hierarchy: 1. Fee schedule

	2. A 3. M 4. M	2. Rates (e.g., hospital, ASC Grouper, provider-specific, procedure modifier, managed care rates, etc.) 3. Manual pricing as necessary (e.g., invoices, multiple surgeries, appeals, transmittals, etc.) 4. BHO or Mental Health encounters only – price the flat file encounters using MCO provider-specific rates
6.	A 1. A 2. A 3. A 4. A	**Audit** the encounter 1. Check for duplicate processed encounters 2. Apply benefit limitations if applicable 3. Check for eligibility 4. Check for TPL
7.	1. M 2. A	**Conduct** final pricing activities for the encounter 1. If a BHO or Mental Health encounter, Claims Processing staff adjusts the payment/pricing based on: a. Third Party Liability payments 2. If an encounter other than BHO or Mental Health, the MMIS adjusts the payment/pricing based on: a. Client co-payments b. Third Party Liability and Medicare payments c. Client payments
8.	A	**END**: Encounter adjudication results are **recorded**

Outcome:
1. Encounter is adjudicated, audited and priced appropriately
2. Processing results are recorded and ready for distribution as necessary

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. MMIS 2. DSS 3. COFRS/CORE 4. CBMS 5. PDCS 6. COLD 7. Web Portal 8. Department LAN (flat file) 9. Batch files from MCOs and BHOs	***Shared Data/Interfaces, Outbound***: 1. Managed care reports to BHOs and MCOs 2. TREO 3. COGNOS data reports to BHOs and MCOs 4. Sample population sent to Health Service Advisory Group (HSGA) for surveys CAHPS

To Be Future Vision:

1. Unique identification field for Managed Care Org
2. Flexibility for users to define fields (for reporting, payment adjudication, etc.) with minimal cost and time
3. Ability to implement user-defined adjudication rules (e.g., to specific populations groups)
4. Electronic attachments
5. Ability to feed information into new DSS that has same type of flexibility as the new MMIS
6. Cooperative relationship between Fiscal Agent and State to implement changes to the system and/or business rules
7. Ability to implement changes quickly
8. Reduce need for operational manual work-around
9. 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.)
10. Identify the true rendering, billing, referring, attending, supervising, operating, and other providers
11. Accept the provider NPI
12. Accept dental encounters
13. Combine all ASO encounters and pay the appropriate ASO plan based on accepted and priced encounters
14. Accept and process CHP+ encounters

Failures of the Current Process:

1. Flat files are required for BHO/mental health encounters
2. MMIS does not allow encounter data to be handled differently between plans
3. MMIS does not allow different users to assign different benefits
4. MMIS does not allow MCO as a type of provider (MCO ID entered in rendering field)
5. Inflexibility of hard-coded claims adjudication rules creates issues
6. Cost and time of changing anything (in either of the systems) adjudication rules; CSR backlog
7. Lack of FTEs to make adjudication rules changes
8. Manual work-around required due to system inflexibility and CSR backlog
9. Limited ability to determine pricing mechanism and/or original rate applied to claim
10. Limited ability to assign encounters 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:

8 – Performance Management Use Cases

Identify Utilization Anomalies – PE01

CO MITA 3.0 SS-A Project

Business Area: Performance Management (PE)
Business Category: Compliance Management
Business Process: Identify Utilization Anomalies
Author(s): Cathy Fielder, Terry Burnham, Max Salazar, Alex Stephens, Robert Lodge, Bonita Kelly, Elaine Osbment, Katherine Quinby, Kim Nguyen
Facilitator: Nicole Wong
Actor(s): Department Staff**,** Providers, Clients, Contractors, Balanced Scorecard, HEDIS – Health Effectiveness and Data Information Set
MITA 3.0 Business Process Description: The **Identify Utilization Anomalies** business process uses criteria and rules to identify target groups (e.g., providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable and unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Internal and external referrals, business intelligence analysis (i.e., historical, current, and predictive views of business operations), and scheduled or on-demand reporting may identify a compliance incident. Identification of utilization anomalies include evaluation of: • Provider utilization review • Provider compliance review • Contractor utilization review (includes managed care organizations) • Contractor compliance review • Member utilization review • Investigation of potential fraud or abuse review • Drug utilization review • Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures) • Performance review (e.g., Key Performance Indicator (KPI)) • Erroneous payment • Contract review • Audit Review • Other evaluation of information Different criteria and rules, relationships, and information define each type of compliance

incident and require different types of external investigation.

CO Business Process Description:
Colorado's **Identify Utilization Anomalies** business process is generally aligned with the MITA 3.0 Framework.

Precondition:

- Claims have been processed
- Contracts in place
- Providers are enrolled
- Clients are enrolled
- PAR
- QI
- Drug Utilization

***Trigger(s)*:**

1. Claims are paid
2. Scheduled monitoring process and report review
3. Alerts, ideas, algorithms, referrals, and models from multiple external sources
4. Audits
5. Denied claims
6. Internal referrals and ideas

Manual (M) or Automated (A)		***Steps:***
		Review process:
1.	M/A	**START**: **Receive** information requiring review
2.	M	**Forward** for assignment
3.	M	**Determine** if review is necessary, appropriately assigned, and scope
4.	M	**END: Forward** to manage compliance incident information or **close** incident; track as appropriate
		Alternate Sequence: Client Overutilization Program (COUP):
1.	M	**START**: **Receive** report from contractor, or **pull** data on identified instances of overutilization
2.	M	**END: Identify** over-utilizers; if appropriate, send warning letter

***Outcome*:**

1. Incident is assigned to appropriate personnel to investigate
2. Incident is closed

As Is Performance Metrics:	***To Be Performance Metrics:***
• Contractor SLAs	• Contractor SLAs

Supporting Performance Metrics/SLA Documentation: • Contractor SLAs	
Shared Data/Interfaces, Inbound: 1. MMIS 2. ESURS 3. DSS (COGNOS/TOAD) 4. CBMS 5. PDCS 6. COLD 7. CMS 8. OSCAR 9. DORA Licensure 10. ASPEN (OASIS) 11. LEIE (Medicare Exclusionary Database) 12. SAM 13. MED (Medicare Exclusionary Database) 14. DEA 15. CMS Termination System 16. DOLE 17. Web Portal 18. BUS 19. DDD Web 20. E-mail and phone communication 21. Audit reports 22. Notifications from federal and state agencies 23. Fraud hotline (i.e. phone and e-mail) 24. Information from other external organizations (e.g. insurance companies)	***Shared Data/Interfaces, Outbound***: 1. E-mail and phone communication 2. Letter to client (COUP)
To Be Future Vision: 1. Predictive analytics capability, with a user friendly GUI (graphical user interface) and display of data 2. Pre-payment review 3. Update all COLD reports 4. All COLD reports are produced out of DSS (instead of production environment) 5. Provider affiliate list in MMIS 6. Provider disclosures in MMIS 7. Any information held in MMIS shall be forwarded to DSS 8. Increase usage of Substance Abuse database (PDMP) by providers, pharmacies, and Department staff	

9. Direct interface for state-to-state databases 10. Direct interface for state-to-federal databases 11. Real-time notification of services, care or goods received (e-prescribing) 12. Customizable provider specific alerts (automated – about their clients, about their licenses, or their specialty) 13. Flexible/Nimble/Configurable/Modular system 14. Integrate existing BUS with MMIS, including two-way communication with CBMS 15. Integrate existing BUS with DDD Web 16. Education around no wrong door
Failures of the Current Process: 1. Manual heavy process 2. Human error (Directing the incident to the appropriate section is complicated; "No wrong door") 3. System reliability 4. Lack of real-time data 5. Lack of interfaces with State/Federal databases 6. File size 7. CSRs take too long and are too expensive
Notes:

Manage Compliance Incident Information – PE03

CO MITA 3.0 SS-A Project

Business Area: Performance Management (PE)

Business Category: Compliance Management

Business Process: Manage Compliance Incident Information

Author(s): Robert Lodge, Terry Burnham, Cathy Fielder, Bonnie Kelly, Elaine Osbment, Max Salazar, Alex Stephens, Katherine Quinby

Facilitator: Nicole Wong

Actor(s): Department Staff**,** Providers, Clients, Contractors, Balanced Scorecard, HEDIS – Health Effectiveness and Data Information Set

MITA 3.0 Business Process Description:
The **Manage Compliance Incident** Information business process is responsible for the monitoring of incidents of utilization anomalies. Activities include referring (e.g., escalation) incident to another incident manager or agency, modifications to incident information, journaling activities, and disposition of incident.

CO Business Process Description:
Colorado's **Manage Compliance Incident Information** business process generally aligns with the MITA 3.0 Framework. In Colorado, the **Manage Compliance Incident Information** business process is responsible for conducting reviews and monitoring of incidents of utilization anomalies.

Precondition:

- **Identify Utilization Anomalies (PE01)** business process (part of the Performance Management business area)

Trigger(s):
1. Receive trigger from **Identify Utilization Anomalies (PE01)** (part of the Performance Management business area) business process
1. Staff periodically reviews incident
2. Staff modifies incident information due to follow-up activities

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** established incident
2.	M	**Review** incident information or allegations for determination of action needed for review
3.	M/A	**Gather** related internal information as needed
4.	M	If applicable, **refer** or **escalate** incident to responsible individual, department or state or federal agency. **Refer** to contractor if applicable

5.	M/A	**Perform** appropriate action: a. **Perform** data query b. **Obtain** medical records, if necessary
6.	M	**Analyze** data output and/or records, or conduct audit for fraud, waste, abuse, overpayments, gaps in system/rules, or required policy changes a. If reviewer suspects fraud, the case is referred to Program Integrity Section b. If overpayments (including waste and abuse) are identified, trigger **Determine Adverse Action Incident (PE04)** business process (part of the Performance Management business area) c. If gaps in system/rules, or required policy changes are identified, refer to policy staff d. Reviewing or auditing staff works with Program and Policy staff to conduct provider outreach as necessary
7.	M	If applicable, **send** alert to notify member via **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area) of incident tracking information
8.	M	If applicable, **send** alert to notify provider via **Manage Provider Communication (PM02)** business process (part of the Provider Management business area) of incident tracking information
9.	M	If applicable, **send** alert to notify contractor via **Manage Contractor Communication (CO02)** business process (part of the Contractor Management business area) of incident tracking information
10.	M	**END: Determine** recommended disposition of incident and if applicable, **send** alert to **Determine Adverse Action Incident (PE04)** business process (part of the Performance Management business area)

***Outcome*:**

1. Monitored incident and tracked
2. Recommended determination of disposition
3. If applicable, alert sent to notify member via **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area) of incident tracking information
4. If applicable, alert sent to notify provider via **Manage Provider Communication (PM02)** business process (part of the Provider Management business area) of incident tracking information
5. If applicable, alert sent to notify contractor via **Manage Contractor Communication (CO02)** business process (part of the Contractor Management business area) of incident tracking information
6. If applicable, alert sent to **Determine Adverse Action Incident (PE04)** business process (part of the Performance Management business area)

<table>
<tr><td colspan="2">7. Tracking information as needed for measuring performance and business activity monitoring
8. Provider education
9. Make policy changes
10. Propose revised rules as applicable
11. Trigger Perform Provider Outreach (PM03) business process (part of the Provider Management business area)</td></tr>
<tr><td>As Is Performance Metrics:
• N/A
Supporting Performance Metrics/SLA Documentation:
• N/A</td><td>To Be Performance Metrics:
• N/A</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. CBMS
2. MMIS
3. Claims data from MCOs
4. Reports of suspected fraud
5. COFRS/CORE
6. Financial Data Warehouse
7. PDCS
8. DSS
9. BUS
10. DDD Web
11. Provider Web Portal
12. Phone, e-mail, mail
13. DOLE
14. SSA</td><td>Shared Data/Interfaces, Outbound:
1. Recovery contractor’s data store
2. Transmittals to the fiscal agent
3. E-mail
4. Provider bulletins</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. Acquisition of predictive analytics prepayment claims review system
2. Automation of case management
3. More automated reports</td></tr>
<tr><td colspan="2">Failures of the Current Process:
1. Rules are not adequate</td></tr>
<tr><td colspan="2">Notes:
Note that in Step 8, provider communication is dictated by statute. CRS 25.5-4-301</td></tr>
</table>

CO MITA 3.0 SS-A Project

Business Area: Performance Management (PE)

Business Category: Compliance Management

Business Process: Determine Adverse Action Incident

Author(s): Robert Lodge, Terry Burnham, Cathy Fielder, Bonita Kelly, Elaine Osbment, Max Salazar, Alex Stephens, Katherine Quinby

Facilitator: Nicole Wong

Actor(s): Department staff, Attorney General's Office, Fiscal Agent, Medicaid Fraud Control Unit (MFCU) staff, State Controller

MITA 3.0 Business Process Description:

The **Determine Adverse Action Incident** business process receives an incident from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, corrective action, removal of a provider, contractor, trading partner or member from the Medicaid Program, or the State Medicaid Agency (SMA) may terminate or suspend the case.

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

- Provider utilization review
- Provider compliance review
- Contractor utilization review (includes managed care organizations)
- Contractor compliance review
- Member utilization review
- Investigation of potential fraud or abuse review
- Drug utilization review
- Quality review (e.g., Consumer Assessment of Healthcare Providers and Systems (CAPHS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures)
- Performance review (e.g., Key Performance Indicator (KPI))
- Contract review
- Erroneous payment review
- Audit Review
- Other evaluation of information

Different criteria and rules, relationships, and information define each type of adverse action incident and require different types of external investigation.

CO Business Process Description:

Colorado's **Determine Adverse Action Incident** business process is generally aligned with

the MITA 3.0 Framework.

Precondition:

- Review has been conducted.

***Trigger(s)*:**

1. Trigger from **Manage Compliance Incident Information (PE03)** business process (part of the Performance Management business area)

Manual (M) or Automated (A)		***Steps:***
		Fee-for-Service Process:
1.	M	**START**: **Receive** recommendation for adverse action
2.	M	**Determine** that adverse action is required based on review
3.	M	END: If recommendation is credible allegation of fraud, **determine** there is a credible allegation of fraud, refer to law enforcement agency, suspend payments if appropriate
4.	M	END: If overpayment is identified, **initiate** recovery and provider education. **Trigger Manage Provider Recoupment (FM01)** (part of Financial Management business area), **Manage TPL Recovery (FM02)** (part of Financial Management business area), and **Manage Provider Communication (PM02)** (part of Provider Management business area business processes
5.	M	END: If termination of provider agreement for cause is needed, **send** adverse action letter and report to appropriate agencies
6.	M	**END: Close** case

***Outcome*:**

1. Trigger **Manage Provider Recoupment (FM01)** (part of Financial Management business area), **Manage TPL Recovery (FM02)** (part of the Financial Management business area), and **Manage Provider Communication (PM02)** (part of the Provider Management business area) business processes
2. Referral for criminal or civil action
3. Provider education/training occurs
4. Providers are terminated, as necessary
5. Clients are protected from fraud, waste, abuse, and criminal activity
6. OIG is notified of provider sanctions (termination, withholding)
7. Program policy rules are updated and system updates are implemented, if required
8. Case closed

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. MMIS	***Shared Data/Interfaces, Outbound*:**

2. DSS 3. COFRS/CORE 4. ESURS 5. Master TCN database 6. PDCS 7. SAS 8. BUS 9. ASPEN (Public Health & Environment database) 10. DORA 11. FBI 12. IRS 13. COLD 14. Homeland Security database 15. Public records research 16. CLEAR 17. LEIE – Excluded Individuals and Entities 18. MED – Medicare Exclusionary Database 19. SAM 20. CMS Termination System	1. CMS Termination System 2. Referral to law enforcement agency 3. Letters to providers 4. Transmittals to fiscal agent 5. Reports to appropriate federal and state agencies 6. E-mails to trigger collections process and offset process 7. CDPHE 8. State ombudsman 9. DORA 10. Termination for cause on external web site

To Be Future Vision:

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

Failures of the Current Process:

1. System does not track previously audited claims and providers for future reference (head-bound knowledge); no way to identify impact on access to care
2. No real-time link to validation databases which creates time and resource issues
3. No systemic pre-payment validation process to identify approved providers prior to payment

4. Time gap between identification of fraud and ability to recover funds 5. Cumbersome process that is time and resource consuming 6. Lack of department policy or regulatory guidance for providers 7. 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:

Prepare REOMB – PE05

CO MITA 3.0 SS-A Project

Business Area: Performance Management (PE)

Business Category: Compliance Management

Business Process: Prepare REOMB

Author(s): Cathy Fielder, Amy Scangarella, Jeremy Sax, Sandra Salus, Elaine Osbment, Bonita Kelly, Lauren Ishida, Jocelyn Parker, Terry Burnam, Sean Bryan

Facilitator: Lindsay Espenship

Actor(s): Department staff**,** Fiscal Agent, Providers, Clients

MITA 3.0 Business Process Description:

The **Prepare REOMB** business process is responsible for the creation of Recipient Explanation of Medicaid Benefits (REOMB) for detecting payment problems. The State Medicaid Agency (SMA) sends the REOMB to randomly selected members of Medicaid services. It gives information on the Medicaid services paid on behalf of the member. The communication includes the provider's name, the date(s) of services, and the payment amount(s). Instructions on the communication tell the member what to do if the provider did not actually perform any of the listed services billed directly to him/her by the provider.

NOTE: This business process does not include the handling of returned information.

CO Business Process Description:

Colorado's **Prepare REOMB** business process is generally aligned with the MITA 3.0 Framework process in place two years that was halted due to HIPAA privacy concerns. The only process in place currently is for durable medical equipment (DME) and supplies, which are reviewed and sent on a semi-annual basis.

Precondition:

- Provider provides DME service
- Transmittals (financials, suspension of service, mass adjustments)
- Confidential Services are excluded from EOMBs

Trigger(s):

1. Adjudication process
2. Provider submits claim (manual or auto, 99% auto)
3. Financial cycle
4. Analyst performs risk assessment for the specific DME

Manual (M) or Automated (A)		***Steps:***
		Fee-for-Service Process:
1.	A	**START**: Claim has been **accepted** in MMIS
2.	A	MMIS **Adjudicates** claim

3.	A	Financial cycle **runs**
4.	M	Analyst **performs** risk assessment of DME reimbursed claims
5.	M	EOMB is **created** for semi-annual EOMB project
6.	M	**END: Send** notification mailed to clients to confirm DME services received

Outcome:
EOMB is prepared and quality is checked to ensure NO confidential services are on any of the EOMBs being sent to clients.

As Is Performance Metrics:	***To Be Performance Metrics:***
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. Web Portal 2. MMIS 3. COLD 4. DSS 5. EDI	***Shared Data/Interfaces, Outbound***: 1.

To Be Future Vision:
1. All electronic
2. Expand DSS to include as many reports as possible from COLD (all reporting in DSS)
3. New DSS to include all information in MMIS
4. Quality Assurance process to ensure Confidential Services are NOT included on any EOMB
5. 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 EOMBs can reach the client
6. Eliminate manual semi-annual DME EOMB risk assessment process
7. Utilize other notification options other than U.S. Mail

Failures of the Current Process:
1. Paper and inefficient manual process
2. Inflexible reporting (MMIS production)
3. Unable to extract confidential services data for HIPAA reporting purposes
4. Client contact information is frequently incorrect

Notes:

9 – Plan Management Use Cases

CO MITA 3.0 SS-A Project

Business Area: Plan Management

Business Category: Plan Administration

Business Process: Develop Agency Goals and Objectives

Author(s): Cathy Fielder, Amy Scangarella, Jeremy Sap, Sandy Salus, Elaine Osbment, Bonnie Kelly, Lauren Ishida, Jocelyn Parker, Terry Burnham, Sean Bryan

Facilitator: Lindsay Espenship

Actor(s): Executive Committee, Leadership Team, Department Managers, Policy Staff (Subject Matter Experts), Fiscal Agent, Governor's Office, State Legislature, Federal Agencies

MITA 3.0 Business Process Description:
The **Develop Agency Goals and Objectives** business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary. Goals and objectives may warrant change for example, under a new administration, in response to changes in demographics, public opinion or medical industry trends, or in response to regional or national disasters.

CO Business Process Description:
Colorado's **Develop Agency Goals and Objectives** business process is generally aligned with the MITA 3.0 Framework.

Precondition:
- Established leadership to define goals and initiatives
- Mission statement is defined

Trigger(s):
1. Executive Order
2. Legislation
3. Scheduled review cycle (e.g., future year's strategic planning, Operational planning schedule, Mid-year progress reporting)
4. Unscheduled event (e.g. a new administration, in response to changes in demographics, public opinion or medical industry trends, or in response to regional or national disasters)

Manual (M) or Automated (A)		***Steps:***
1.	M	**START:** A trigger **initiates** this process to develop agency goals and objectives
2.	M	**Identify** internal subject matter experts for the strategic goals and objectives
3.	M	**Develop** benchmarks as they relate to the strategic goals and objectives
4.	M	**Gather** historic and preliminary data as it relates to the strategic goals

		and objectives
5.	M	**Review**, **analyze** and **refine** the benchmark as necessary
6.	M	**Submit** revised strategic plan and benchmarks to Executive Committee for review and approval
7.	M	**Submit** Strategic Plan changes to the Governor's office for review and approval
8.	M	**Monitor** approved future-year benchmarks to ensure they are measureable; identify additional measurement possibilities
9.	M	**Deliver** approved strategic plan to General Assembly on November 1 as part of the annual budget request
10.	M	**END**: **Post** the approved strategic plan to HCPF's website

Outcome:

1. Agency goals and objectives are established or revised, progress is measured at least semi-annually, and reported annually.

As Is Performance Metrics:	***To Be Performance Metrics:***
N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. General assembly 2. Executive Orders to include Department Executive 3. Federal directives 4. COFRS/CORE 5. MMIS 6. CBMS 7. DSS	***Shared Data/Interfaces, Outbound***: 1. Published to the public Website on 11/1 every year as a required component of the annual budget request 2. Provide information to Governor's Office for Publishing Governor's Office of Planning and Budgeting – website

To Be Future Vision:

1. Ability to link reports to every year's strategic benchmarks
2. Ad hoc reporting
3. New DSS to provide consistent reporting against benchmarks
4. 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/
5. Enforce consistent use of standardized process for setting measureable goals; create depth of understanding
6. Integrate operational and strategic goals into department job descriptions and employee performance evaluation plans to enhance accountability and employee buy-in
7. Automate and achieve real-time reporting on benchmark progress

Failures of the Current Process:
1. 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) 2. High turn-over impacts this business process due to heavy reliance on manual reporting processes and individual subject matter expertise 3. There is no standardized policy that links the department strategic and operational goals to individual employee performance measures or job duties
Notes:

Maintain Program Policy – PL02

CO MITA 3.0 SS-A Project

Business Area: Plan Management		
Business Category: Plan Administration		
Business Process: Maintain Program Policy		
Author(s): Cathy Fielder, Jeremy Sax, Tom Leahey, Jerry Smallwood, Rachel Deshay, Sean Bryan		
Facilitator: Lindsay Espenship		
Actor(s): Department staff, Federal and State government, stakeholders (e.g., providers, clients, advocates), other State agencies, Legal Division		
MITA 3.0 Business Process Description: The **Maintain Program Policy** Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as federal or state regulations, governing board or commission directives, Quality Improvement Organization's findings, federal or state audits, enterprise decisions, or consumer pressure. ***CO Business Process Description:*** Colorado's **Develop and Maintain Program Policy** business process is generally aligned with the MITA 3.0 Framework. Colorado's business process also includes proactive Department initiatives.		
Precondition: • Established Medicaid program goals and objectives • Department strategic plan in place • Ongoing process improvement programs (Triple Aim)		
Trigger(s): 1. Legislation (State and Federal) 2. Federal Regulatory Changes 3. Budget actions 4. Audit findings 5. Stakeholder pressure 6. Technology changes 7. Client need 8. Appeals decisions / legal action 9. Identification of / changes in best practices 10. Need for policy clarification/definition		
Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: Designated Department staff **monitors** various communication channels

2.	M	Designated Department staff **determines** high-level impact on the Department
3.	M	Designated Department staff **sends** notification to the appropriate staff
4.	M	Department staff **interprets** impact on the stakeholders
5.	M	Department staff **drafts** policy change and implementation plan, with internal and external stakeholder involvement
6.	M	**Determine** if rule change, state plan amendment (SPA), or contract amendment are needed
7.	M	**Determine** if significant changes to claims/payment systems are required to implement the change
8.	M/A	**Coordinate** internal clearance
9.	M	**Request** funding and approval, if required
10.	M	**Execute** CMS, legislative, and internal approvals
11.	M	**Communicate** changes
12.	M	**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

As Is Performance Metrics:	***To Be Performance Metrics:***
• Executed contracts must be submitted to CMS 45 days prior to effective date. ***Supporting Performance Metrics/SLA Documentation:*** • CMS Requirements	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. SharePoint 2. MMIS (generates provider claim reports) 3. DSS 4. PDCS 5. BUS 6. CBMS 7. Website 8. Web Portal 9. Email 10. COFRS/CORE 11. US Mail	***Shared Data/Interfaces, Outbound***: 1. Website 2. Mail 3. Web Portal 4. Email 5. SharePoint Any changes may affect output of: 1. MMIS 2. BUS 3. DSS 4. PDCS 5. CBMS

Maintain Program Policy – PL02

To Be Future Vision:

1. More flexible/configurable systems
2. Modular systems based on service delivery more than payment/claim type
3. MMIS documentation specific to each high level service that can be reviewed each time major policy changes are made
4. Service Oriented Architecture
5. Standardize process inputs
6. Streamline process
7. Document process
8. Communication architecture
9. Improved management of the long cycle
10. Be able to identify appropriate segments of stakeholders for input and participation

Failures of the Current Process:

1. Designated Department staff not always notified
2. Not always known which Department staff are appropriate (referred to as "Designated Department staff" in steps above)
3. Communication failures
4. Stakeholder identification issues
5. Staff turnover/retention
6. Institutional knowledge of unique programs, regular updates, and special manual workarounds are not documented and are managed by solo individuals. Loss of such individuals leads to significant risk.
7. Process not standardized/defined
8. Insufficient funding
9. System limitations due to antiquated MMIS
10. Current MMIS is payment-type based and not grouped in a way that makes logical sense to policymakers
11. No historical policy information
12. Long cycle
13. Funds appropriation
14. Unrealistic timelines

Notes:

Maintain State Plan – PL03

CO MITA 3.0 SS-A Project

Business Area: Plan Management		
Business Category: Plan Administration		
Business Process: Maintain State Plan		
Author(s): Cathy Fielder, Jeremy Sax, Tom Leahey, Jerry Smallwood, Rachel Deshay, Sean Bryan, Judith Carey, Max Salazar		
Facilitator: Lindsay Espenship		
Actor(s): CMS, Department Staff, Tribal Groups, Stakeholders, Medical Services Board		
MITA 3.0 Business Process Description: The **Maintain State Plan** business process responds to the scheduled and unscheduled prompts to update and revise the Medicaid State Plan. The Medicaid State Plan is the officially recognized statement describing the nature and scope of the State Medicaid program as required under Section 1902 of the Social Security Act. ***CO Business Process Description:*** Colorado's **Maintain State Plan** business process is generally aligned with the MITA 3.0 Framework.		
Precondition: • State Plan		
Trigger(s): 1. Identification of outdated State Plan 2. State Plan review 3. Policy change requiring State Plan Amendment 4. State / Federal legislation requiring state plan amendment		
Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: State Plan Coordinator **receives** notification or identifies that a change to the State Plan is required
2.	M	**Identify** the pages of the State Plan that need to change. Consult with other Department staff, if necessary
3.	M	**Edit** the pages with required changes
4.	M	**Request** Transmittal Number (TN) from legal division
5.	M	**Complete** State Plan submittal paperwork
6.	M/A	**Coordinate** internal clearance
7.	M/A	**Send** draft of State Plan Amendment (SPA) to CMS
8.	M	**Complete** Tribal consultation
9.	M	**Issue** public notice, if necessary

10.	M	**Adjust** language and paperwork, as needed
11.	M	**Receive** final Departmental clearance
12.	M/A	Legal Division **submits** to CMS
13.	M	Legal Division **receives** official response from CMS, within 90 days
14.	M	Department staff **responds** to CMS informal request for information, if requested
15.	M	Legal Division **responds** to CMS formal request for information with a new version of the State Plan Amendment, if requested, within 90 days and signed by the office director
16.	M	Legal Division **receives** official response from CMS, within 90 days
17.	M	Legal Division **updates** website with approved pages
18.	M	**END**: **Implement** SPAs with Medical Services Board (MSB) Rulemaking process, as needed

Outcome:
1. State Plan is maintained and current

As Is Performance Metrics:	***To Be Performance Metrics:***
• Response to CMS within 90 days • Response from CMS within 90 days ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. Website 2. Tribal consult repository 3. Public meetings with stakeholders 4. Transmittal from Legal Division	***Shared Data/Interfaces, Outbound***: 1. CMS 2. Website (updated by Legal Division) 3. Updates to State Plan

To Be Future Vision:
1. More flexible/configurable systems
2. Modular systems based on service delivery more than payment/claim type
3. MMIS documentation specific to each high level service that can be reviewed each time major policy changes are made
4. Service Oriented Architecture
5. Standardize process inputs
6. Streamline process
7. Document process
8. Communication architecture
9. Improved management of the long cycle
10. Be able to identify appropriate segments of stakeholders for input and participation
11. Educate staff on how to access the State Plan

Maintain State Plan – PL03

Failures of the Current Process:
1. Slow turnaround by CMS 2. Improved approval process – automated 3. Pre-approval process 4. Standardized process 5. Word Document (or other editable format) versions of all state plan pages, past versions included, maintained within the Department and available for editing
Notes:

CO MITA 3.0 SS-A Project

Business Area: Plan Management
Business Category: Health Plan Administration
Business Process: Manage Health Plan Information
Author(s): Joey Gallegos, Jim Becker, Joan Welch, Nathan Culkin, Jerry Smallwood, Whitney Zanotelli, Joceyln Parker, Cathy Fielder, Rene Horton, Sean Bryan, Rachel DeShay
Facilitator: Nicole Wong
Actor(s): Department Staff, Providers, Public, Legislature, Auditors, CMS, OSPB, Contractors
MITA 3.0 Business Process Description: The **Manage Health Plan Information** business process includes evaluation of federal or state regulations, legislative and judicial mandates, federal or state audits, governing board or commission directives, Quality Improvement Organization's findings, enterprise decisions, and consumer pressure to develop or enhance enterprise business rules, benefit plans and services available to members. The State Medicaid Agency (SMA) collaboratively develops Health Plan service offerings with input and review by other agencies and stakeholders. This business process ensures the organization is on track with the goals and objectives of the SMA and is in concert with statewide goals. ***CO Business Process Description:*** Colorado's **Manage Health Plan Information** business process is mostly aligned with the MITA 3.0 Framework. It references the operational aspects of the MMIS/DSS, specifically the analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions, and also serves to develop or enhance enterprise business rules, benefit plans and services available to members. Plan evaluation and resulting changes are described as part of the MMIS/DSS information processing and analysis, and a collaborative effort from various agencies and stakeholders.
Precondition: • 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 HCPF staff) to records in MMIS processed successfully • System generated update processes run successfully
Trigger(s):

1. Need for program information
2. Need to change information
3. Addition of new programs
4. Federal and State reporting requirements
5. Contract reporting requirements
6. External data requests
7. Requests for data by other state agencies (e.g., DHS)
8. Litigation
9. Requests from Legislators

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** a request for information
2.	M	**Determine** feasibility (data availability and level of effort) and HIPAA compliance of request
3.	M	**Develop** a project plan to complete the request
4.	M	**Document** request, plan, assumptions, methodology, and best practices research (e.g. SPA, benefits provided by other State's, MMIS data of current benefits)
5.	M	**Execute** project plan
6.	M/A	**Draft or Create** a preliminary report of the new information or data gathered
7.	M	**Conduct** peer review
8.	M/A	**Coordinate** clearance process, if needed
9.	M	**Modify** reports and redistribute, if needed
10.	M	**END: Distribute** the final product to requestor

Outcome:

1. Requests for information are fulfilled.

As Is Performance Metrics:	***To Be Performance Metrics:***
• Achievement of goals and objectives linked to policy implementation • Information is provided within the timeframe requested. • Acknowledgement within 48 hours of request – Department SOP • Respond accordingly to Department policy, or the state or federal law, per the type of request ***Supporting Performance Metrics/SLA Documentation:*** • Department policy	• Customer satisfaction rating
Shared Data/Interfaces, Inbound:	***Shared Data/Interfaces,***

1. Maximus 2. MMIS 3. DSS 4. COFRS/CORE 5. CBMS 6. TRAILS 7. COBA 8. PDCS 9. BUS 10. COLD Reports 11. CMS 12. HEDIS 13. BHO Flat Files 14. NEMT Flat Files 15. HMS 16. Spyder 17. AHRQ 18. DORA 19. SDAC 20. CCMS/DDD Web 21. CDPHE- (e.g. vital stats and ASPEN)	***Outbound*:** 1. CDPHE 2. SDAC (RCCOs) 3. Maximus 4. DSS 5. PDCS 6. MMIS (Contractors and PCMPs) 7. CBMS 8. BUS 9. APCD 10. COFRS/CORE 11. COLD Reports 12. CMS 13. HSAG 14. HEDIS
To Be Future Vision: 1. New BIDM 2. New MMIS interChange 3. Bi-directional interface between the MMIS interChange and CBMS 4. Complete Medicare data 5. Interfaces with external data sources 6. Secured data delivery system including capacity for large volumes of data (sFTP) 7. Interfaces between contractors and external data sources 8. All reporting should happen out of BIDM 9. Improved reporting capability, ability for ad hoc reporting 10. Ability to risk adjust the data 11. External role based access to reports and information 12. Incorporation of other datasets into MMIS / BIDM (e.g. COFRS/CORE, BENDEX, SDX, etc.) 13. Geocoding and mapping capabilities integrated with BIDM 14. Front-end statistical software (e.g. SAS, SPSS) with direct access to BIDM, enables the use of pre-existing code and programs (e.g. AHRQ's, PQIs, and PDIs)	
Failures of the Current Process: 1. Files don't load successfully to MMIS 2. Data is not available 3. High level of effort to retrieve data 4. Inaccurate data	

5. Privacy concerns (Vital Statistics) 6. Limited integrated mapping capabilities, no geocoding capability 7. Limited access to specialized software to prepare and report measures (e.g. statistical and mapping software) 8. Timing with SDAC and MMIS interChange 9. DORA is only checked on an annual basis 10. Manual processes 11. Inflexible interfaces
Notes:

Manage Performance Measures – PL05

CO MITA 3.0 SS-A Project

Business Area: Plan Management
Business Category: Health Plan Administration
Business Process: Manage Performance Measures
Author(s): Joey Gallegos, Jim Becker, Joan Welch, Nathan Culkin, Jerry Smallwood, Whitney Zanotelli, Joceyln Parker, Cathy Fielder, Rene Horton, Sean Bryan, Rachel DeShay, Katie Brookler, Camille Harding, Tom Whalen
Facilitator: Nicole Wong
Actor(s): Contractors, Department Staff, Other State Agencies, Other Agencies, CMS, Legislature, Auditors, Providers, Public
MITA 3.0 Business Process Description: The **Manage Performance Measures** business process involves the design, implementation, and maintenance of mechanisms and measures the State Medicaid Agency (SMA) uses to monitor the business activities and performance of the State Medicaid Enterprise's business processes and programs. This includes the steps involved in defining the criteria by which the SMA measures activities and programs (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Healthcare Effectiveness Data and Information Set (HEDIS) measures). This business process develops the reports and other mechanisms that it uses to track activity and effectiveness at all levels of monitoring. Business Intelligence analysis (i.e., historical, current and predictive views of business operations) occurs within this process. Examples of performance measures and associated reports may be things such as: **Goal**: The SMA makes prompt and accurate payments to providers **Measurement**: Pay or deny 95% of all clean claims within 30 days of receipt **Mechanism**: The SMA generates weekly report on claims processing timelines **Goal**: Accurately and efficiently, draw and report funds in accordance with the federal Cash Management Improvement Act (CMIA) and general cash management principles and timeframes to maximize non-general fund recovery **Measurement**: Draw 98% of funds with the minimum time allowed under CMIA **Mechanism**: The SMA generates monthly report on funds drawn ***CO Business Process Description:*** Colorado's **Manage Performance Measures** business process generally aligns with the business process description, but the examples above are operational rather than

programmatic.

Precondition:

NOTE: Any MITA business process could be a predecessor to any performance monitoring activity depending on the performance measures.

- **Develop Agency Goals and Objectives (PL01)** (part of the Plan Management business area)
- **Maintain Program Policy (PL02)** (part of the Plan Management business area)
- **Maintain State Plan (PL03)** (part of the Plan Management business area)
- **Manage Health Plan Information (PL04)** (part of the Plan Management business area)
- **Identify Utilization Anomalies (PE01)** (part of the Performance Management business area)
- **Manage Compliance Incident Information (PE03)** (part of the Performance Management business area)
- **Financial Management** business processes

***Trigger(s)*:**

1. Receive request to revise or develop new performance measures and/or reporting
2. Notification of a periodic review of measures and/or reporting is due
3. Receive notification for executing a periodic monitoring activity
4. Receive notice describing an incident requiring monitoring.
5. Regulatory mandated performance monitoring
6. Legislation mandated performance monitoring
7. Corrective action order

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** request or reach scheduled review time
2.	M	**Review** existing performance measures and reports
3.	M	**Revise, delete** or **add** to existing measures and reports
4.	M	**Produce** or **update** definition of performance measures
5.	M/A	**Monitor** business activity against established performance measures
6.	M	**Assess** resulting information with business intelligence methods (i.e., historical, current and predictive views of business operations)
7.	M/A	**Produce or update** measures and reports
8.	M/A	**END**: **Disseminate** information to requestor or agency (e.g., individuals or business processes)

Outcome:

1. Update to the criteria, mechanisms, and/or reports utilized to monitor performance

<table>
<tr><td colspan="2">measures
2. Produce reporting related to the incident analysis or periodic monitoring results
3. Tracking information, as needed, for measuring performance and business activity monitoring</td></tr>
<tr><td>As Is Performance Metrics:
• Data Analysis has this information available on time to complete process but reports not currently produced

Supporting Performance Metrics/SLA Documentation:
• N/A</td><td>To Be Performance Metrics:
• Surveying ability in the MMIS interChange
• Ease of implementation of performance measures
• Effectiveness of performance measures</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. Business Activity data store including performance information (e.g., CAHPS and HEDIS measures)
2. Contractors
3. MMIS
4. DSS
5. COFRS/CORE
6. CBMS
7. TRAILS
8. COBA
9. PDCS
10. BUS
11. COLD Reports
12. CMS
13. BHO Flat Files
14. NEMT Flat Files
15. HMS
16. AHRQ
17. DORA
18. CCMS/DDD Web
19. CDPHE - (e.g. vital stats and ASPEN)</td><td>Shared Data/Interfaces, Outbound:
1. CAHPS
2. HEDIS
3. CMS
4. Contractors
5. Department Staff</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. Tracking information, as needed, for measuring performance and business activity monitoring.
2. Increased automation
3. More sources of inbound raw data (e.g., census data, EHR, public health)</td></tr>
</table>

Manage Performance Measures – PL05

4. Real time data 5. Bi-directional interfaces 6. No submission of flat files
Failures of the Current Process: 1. Inability to access relevant information. 2. Manual processes 3. Timing problems 4. Lack of enforcement of performance measures
Notes:

CO MITA 3.0 SS-A Project

Business Area: Plan Management
Business Category: Health Benefit Administration
Business Process: Manage Health Benefit Information
Author(s): Beth Martin, Tom Leahey, Joey Gallegos, Amy Scangarella, Jerry Smallwood, Rachel DeShay, Joan Welch, Kimberley Smith
Other Attendance (non-participating): Karl Schnur (SD)
Facilitator: Lindsay Espenship
Actor(s): Providers, clients, advocates, legislation, Department Staff, JBC/OSPB, CMS, Contractors, Other State Agencies
MITA 3.0 Business Process Description: The **Manage Health Benefit Information** business process includes the activities for development and implementation of health benefit packages to accommodate service delivery to targeted member populations. The health benefit package accommodates information to support current and future health benefit packages for members eligible for programs administered by the State Medicaid Agency (SMA). The SMA determines benefit terms and limitations, and applicable periods for services defined within a health benefit package. Health benefit package administration involves the ability to determine, define and coordinate and modify the following parameters within the SMA, as the Medicaid Enterprise policies, funding and business decisions dictate: • Multiple health benefit package definitions targeted to specific populations. • Service categories to define available covered service. • Federal and state regulations define service limitations to restrict utilization. • Customization of edits and audits relative to SMA policy. • Utilization tracking of limited services at the member level. • Generation of state and federal reporting requirements. ***CO Business Process Description:*** Colorado's **Manage Health Benefit Information** business process is generally aligned with the MITA 3.0 Framework. In Colorado, 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.
Precondition: • Receipt of new legislation (State or Federal), budget request, and internal initiatives

Manage Health Benefit Information – PL06

***Trigger(s)*:**

1. 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
2. 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	**START**: **Receipt** of a request, idea or legislative action
2.	M	**Evaluate** Medicare policy against Medicaid policy to identify conflicts
3.	M	**Conduct** benefits collaborative process including: 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
4.	M	**Research** requirements and recommendations and identify implementation constraints
5.	M	**Make** a coverage determination
6.	M	**Follow** rule making and/or State Plan Amendment process
7.	M	**Procure** vendor (if necessary)
8.	M	**Develop** and finalize the coverage requirements and/or recommendations identifying new or modified benefits
9.	M	**Communicate** health benefit information to stakeholders, providers, and users
10.	M	**Develop, design,** and **implement** any system changes
11.	M	**END**: **Attach** rate to benefit, define other limiting criteria, and load into MMIS

Manage Health Benefit Information – PL06

Outcome: 1. Claims are processed and paid 2. Services are available to be delivered by approved providers to clients 3. Benefit is added or updates made to state plan or waiver	
As Is Performance Metrics: • N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	***To Be Performance Metrics:*** • N/A
Shared Data/Interfaces, Inbound: 1. Data coming in from CBMS (benefit package) 2. CMS data 3. BUS 4. DSS 5. MMIS 6. PDCS 7. Contractors	***Shared Data/Interfaces, Outbound***: 1. DSS 2. Provider Portal 3. Contractors
To Be Future Vision: 1. LTC needs to be integrated into benefits collaborative 2. Infinite flexibility on which providers can bill for a service and which clients can receive a service 3. Establish coverage criteria within policy (current system limitation) 4. Modular, flexibility and updateable 5. Repeatable consistent process 6. Tools to obtain efficacy 7. System integration; e.g., UM vendor or any vendor outside of fiscal agent 8. Granular definition of benefits package in BIDM 9. Implement a way to show more accountability for providers 10. Enhanced reporting	
Failures of the Current Process: 1. System limitations 2. Lack of documented processes 3. Lack of timeliness of the process	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Plan Management
Business Category: Health Benefits Administration
Business Process: Manage Reference Information
Author(s): Beth Martin, Tom Leahey, Joey Gallegos, Amy Scangarella, Jerry Smallwood, Rachel DeShay, Joan Welch
Other Attendance (non-participating): Karl Schnur (SD)
Facilitator: Lindsay Espenship
Actor(s): Department Staff, Fiscal Agent, External Stakeholders (P&T committee, DUR board), CMS, Drug Manufacturers, Contractors, Publishers of the standard code sets
MITA 3.0 Business Process Description: The **Manage Reference Information** business process is responsible for all operations aspects for the creation, modification, and deletions of reference code information. The **Process Claim (OM07)** business process (part of the Operations Management business area) additions or adjustments trigger this business process. Additional triggers for **Manage Reference Information (PL07)** business process (part of the Plan Management business area) includes the addition of a new health plan or benefit, or the modification to an existing program due to the passage of new state or federal legislation, or budgetary modifications. The business process includes revising code information (e.g., Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), National Drug Code (NDC)), and/or revenue codes. Business process also adds rates associated with those codes and updates existing rates. The business process updates and adds information from the **Manage Member Information (ME01)** and **Manage Provider Information (PM01)** business processes (part of the Member Management and Provider Management business areas) as well as drug formulary, health plan and health benefit information. Designate Approved Services and Drug Formulary The Designate Approved Services and Drug Formulary activity is responsible for review of new and/or modified service codes (e.g., HCPCS, International Classification of Diseases (ICD) or NDC) for possible inclusion in various Medicaid Benefit programs. The State Medicaid Agency (SMA) may include or exclude certain services and drugs in each benefit package. Internal or external team(s) of medical, policy, and rates staff review service, supply, and drug codes to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that the SMA will meet. Review includes the identification of any modifications or additions needed for regulations, policies, and or Medicaid State Plan in order to accommodate the inclusion or exclusion of service/drug

codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.

CO Business Process Description:
Colorado's **Manage Reference Information** business process is generally aligned with the MITA 3.0 Framework.

Precondition:
Services and Supplies:
- Need for service
- Published revised code sets

Formulary:
- Receive contract offers from drug manufacturers and receive DRAMS rebate information from Fiscal Agent
- Utilization analysis

***Trigger(s)*:**
1. New or revised legislation
2. Receive codes (data) from CMS
3. New technology and products
4. New safety or clinical information
5. Adoption of a new code

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receive** list of codes
2.	M	**Route** list to review team e.g., HCPCS 2012, benefits management team
3.	M	List is **reviewed** by each of the benefits managers e.g., for need for service or services that will be combined, policy changes
4.	M	**Send** approved list to Budget
5.	M	Budget **calculates** fiscal impact and identifies any statutory issues
6.	M	Budget **routes** through appropriate clearance process (which could be internal or external)
7.	M	List **comes back** to benefits management for review to implement into system through transmittal process
8.	M	**END**: **Publish** to providers
		Alternate Sequence for Formulary:
1.	M	**START**: **Review** claims utilization
2.	M	**Identify** areas (e.g., potentials for cost savings, inappropriate use, supplemental rebate opportunities, new products for new information – safety, etc.)
3.	M	**Bring** information to quarterly stakeholder meetings, as needed
4.	M	Stakeholders **provide** clinical recommendations to process, as needed
5.	M	**Make** formulary decisions based on clinical recommendations and

		determine fiscal impact
6.	M	**Follow** internal clearance process
7.	M	**Cooperate** with manufacturers to set up supplemental rebate contracts, as needed
8.	M	**Make** PDCS system changes based on Formulary, as needed (Note that NDCs are automatically loaded into the PDCS system via the FDB)
9.	M	**END**: **Communicate** to stakeholders

Outcome:
1. Cost savings
2. Availability of services and benefits for clients
3. Availability of data for analysis
4. Update of new codes in the system

As Is Performance Metrics:
- PDL updated on a quarterly basis
- Other benefit decisions are made on an ad hoc basis
- Annual HCPCS, DRG, diagnosis
- CMS updates as needed
- NCCI quarterly update
- NUBC as needed

Supporting Performance Metrics/SLA Documentation:
- Medicaid Rule
- CMS Guidelines

To Be Performance Metrics:
- Annual updates of NUBC
- Implement coding process within 60 days

Shared Data/Interfaces, Inbound:
1. PDCS
2. MMIS
3. DSS
4. DRAMS
5. Pricing contractor
6. DUR contractor
7. Data from CMS
8. Fiscal Agent transmittal
9. P&T committee – utilization analysis and market share analysis reports
10. Data from code set publishers

Shared Data/Interfaces, Outbound:
1. DSS
2. Contractors
3. Providers
4. Web Site

To Be Future Vision:
1. Streamline rebate information process (getting information from Fiscal Agent)
2. Adding rebate information into BIDM
3. Interface for Drug manufacturers to directly input contract offers into system
4. Receive CMS file in user-friendly format

5. Application that communicates to providers and clients the changes on available products (is currently sent out via email blast) 6. System feedback associated with claims in BIDM (to see if it was preferred or not preferred at the time the claim was paid) 7. System capable of automatically incorporating published code sets 8. Incorporate HIPAA claim adjustment and reason codes in the MMIS and be able to cross reference them to MMIS edits and benefit determinations 9. Update code sets in a standardized manner
Failures of the Current Process: 1. Not receiving CMS report timely 2. Processes are too manual/ too many man-hours 3. Rebate information is not in DSS 4. Code sets are out of date 5. Too many workarounds 6. Provider confusion
Notes:

Manage Rate Setting – PL08

CO MITA 3.0 SS-A Project

Business Area: Plan Management
Business Category: Health Benefit Administration
Business Process: Manage Rate Setting
Author(s): Cathy Fielder, Karen Janulewicz, Diana Lambe, Laurie Stephens, Christina Chavez, Nicholas Clark, Jason Takaki, Marguerite Richardson, Marceil Case, Jeff Wittreich, Jeremy Sax, Joan Welch, Jocelyn Parker, Dianne Hinricher, Rene Horton, John Aldag, Sarah Roberts
Other Attendance (non-participating): Karl Schnur (SD)
Facilitator: Lindsay Espenship
Actor(s): Providers, Legislation, Contractors, Department Staff, JBC/OSPB, Fiscal Agent, CMS
MITA 3.0 Business Process Description: The **Manage Rate Setting** business process responds to requests to add or modify rates for any service or product covered by the Medicaid Program. ***CO Business Process Description:*** Colorado's **Manage Rate Setting** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • A provider submits a request for reimbursement for Medicaid
Trigger(s): 1. 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 2. 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

Manage Rate Setting – PL08

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Review** category of service and existing reimbursement policy, if applicable, according to Department policy schedule
2.	M	**Determine** if benefit/rate methodology is existing or new a. For new benefit/rate methodology: **Develop** policy (e.g., define other limiting criteria), 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 (e.g., define other limiting criteria), and procedures (includes timing)
3.	M	**Communicate** rates to stakeholders
4.	M	**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.	M	**END**: **Attach** rate to benefit and load into MMIS

Outcome:
1. Rate is updated, added and paid

As Is Performance Metrics:	***To Be Performance Metrics:***
• Annual review of rates, for example; BHO, Nursing Facilities, In-patient hospital, HMO, PACE, CHP+, FQHC • Ad hoc updates, for example, Fee schedule • Provider updates, as needed ***Supporting Performance Metrics/SLA Documentation:*** • MCO Contracts • Med 13 Cost Report (Nursing Facility) • CMS Guidelines • State Statutes	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. Pharmacy ingredient costs 2. Cost reports 3. Automated pharmacy rate vendor, i.e., Mercer 4. CMS data 5. MMIS 6. DSS (rate tables) 7. BHO Flat Files 8. HMO Flat Files 9. PDCS	***Shared Data/Interfaces, Outbound***: 1. Actuary Certification Letters 2. Web Site/Fee Schedule 3. Rate Letters 4. Contractors 5. Website/Pharmacy Prices 6. APCD 7. Provider Bulletins

10. Appeals	
To Be Future Vision: 1. 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 2. Real time determination and communication 3. Flexible (e.g., based on provider and client type) 4. Modular 5. User Updateable 6. Department staff can update the individual rates without having to send in a transmittal letter	
Failures of the Current Process: 1. No approval 2. Denial of rate setting 3. Delayed notification 4. Rate not making it in system in time 5. System limitations to implement the methodology 6. Inefficient and burdensome 7. Lack of training on processes 8. Lack of documented standard procedures 9. Lack of communications 10. Parallel system for encounter data does not exist 11. Manual workarounds built into system a. For example, encounter data (logic) is put in FFS system; creates conflict between encounter claims 12. System integration; e.g., UM vendor or any vendor outside of fiscal agent 13. Risk for human error	
Notes:	

10 – Provider Management Use Cases

CO MITA 3.0 SS-A Project

Business Area: Provider Management
Business Category: Provider Information Management
Business Process: Manage Provider Information
Author(s): Cathy Fielder, Karen Janulewicz, Diana Lambe, Evan Grimes, Laurie Stephens, Christina Chavez, Nicholas Clark, Jason Takaki Marguerite Richards, Marceil Case, Jeff Wittreich, Jeremy Sax, Joan Welch, Jocelyn Parker, Dianne Hinricher, Rene Horton, John Aldag
Other Attendance (non-participating): Karl Schnur (SD)
Facilitator: Lindsay Espenship
Actor(s): Fiscal Agent, Web Portal, Department Staff, Providers, Contractors, CMS, Other State and Federal Agencies
MITA 3.0 Business Process Description: The **Manage Provider Information** business process is responsible for managing all operational aspects of the Provider data store, which is the source of comprehensive information about prospective and contracted providers and their interactions with the State Medicaid Agency (SMA). The Provider data store is the SMA Source of Record (SOR) for provider demographic, business, credentialing, enumeration, performance profiles, payment processing, and tax information. The data store includes contractual terms (e.g., the services the provider is to provide) related performance measures, and the reimbursement rates for those services. In addition, the Provider data store contains records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification, and all communications with or about the provider, including provider verification requests and responses, and interactions related to any grievance/appeal. The Provider data store may store records or pointers to records for services requested and services provided, performance, utilization, and program integrity reviews, and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the Member data store to add, delete, or modify information. The Provider data store validates information upload requests, applies instructions, and tracks activity. The Provider data store provides access to provider records to applications and staff via batch record transfers, responses to queries, and subscription services. ***CO Business Process Description:*** Colorado's **Manage Provider Information** business process is generally aligned with the MITA 3.0 Framework.
Precondition:

- Written information from provider or Department. Receipt of application or correspondence from prospective or current provider.

Trigger(s):
1. Receipt of application or written information
2. Correspondence from provider in form of mail or phone call
3. Entry or update of information on web portal
4. Department sends transmittal to fiscal agent
5. Returned correspondence (via mail)
6. External data feeds for excluded status, licensure validation
7. Provider Background results

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: **Receipt** of documentation by the Fiscal Agent
2.	M	**Verify** documentation for accuracy and completion
3.	M	Fiscal Agent **enters** updates to MMIS, except when State approval required
4.	M	If State approval required, request is **sent** to appropriate person at State for approval
5.	M	**Review** completed by state
6.	M	**END: Notify** Fiscal Agent of approval via transmittal
		Alternate Sequence: Web Portal
1.	M	**START**: **Enter** updates directly into the web portal (only if provider is eligible to make the update)
2.	M	Authorized provider **submits** updates
3.	A	**END:** Interface **updates** MMIS within 24 hours

Outcome:
1. MMIS is updated with current provider information

As Is Performance Metrics:
- Fiscal agent has 5-8 business days to process transmittals
- Error rate per fiscal agent contract
- Web Portal Interface updates MMIS within 24 hours

Supporting Performance Metrics/SLA Documentation:
- Fiscal Agent Contract

To Be Performance Metrics:
- N/A

Shared Data/Interfaces, Inbound:
1. Web Portal Interface – manual & automated
2. State Controllers Office (COFRS/CORE) – currently manual
3. MMIS
4. Trackwise

Shared Data/Interfaces, Outbound:
1. COFRS/CORE
2. MMIS
3. Contractors

5. DSS 6. State Share 7. ASPEN – DPHE – manual process 8. TPMS – manual & automated 9. DORA - manual on initial enrollment 10. National Plan and Provider Enumeration System (NPPES) - manual process 11. OIG 12. OSCAR database – manual on enrollment 13. LEIE 14. Validation of Zip Code (and/or entire address) with external interface 15. SAM (System for Awards Management) 16. PDCS	4. DSS 5. PDCS 6. Web Portal

To Be Future Vision:

1. Paperless
2. Interface with ASPEN to cross reference providers
3. Interface with DORA
4. Interface with all accreditation agencies
5. Interface with NLR (National Level Repository)
6. Ability to accept electronic signature
7. Ability to accept electronic documents
8. Interface with vital statistics
9. Interface with Internal Revenue Service
10. Interface with PECOS
11. Audit capabilities
12. Have provider ALERTS that give notice of pending CLIA, facility or professional license expiration.
13. 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.
14. Require providers to update / confirm all enrollment data within 30 days of a change.
15. Include tables to store all required provider disclosures, e.g., Ownership/relationship of owners, Managing Employees, Significant Transactions, Affiliations with other provider IDs.
16. Have capability to query and pull reports of all provider disclosure information.
17. Have capability to enroll in-home caregivers and managed care network providers.
18. 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.
19. All claims should use license status to price claims. When licenses expire, all claims are to deny until provider submits updates to licensure status.
20. Require provider specialty information e.g., capture Taxonomy ID

21. Ability to capture employment information on clinical staff, e.g., load capacity 22. Interface with Social Security Death master file
Failures of the Current Process: 1. Mail 2. Human error (delay and inaccuracy) 3. Current MMIS unable to identify all provider locations for each specialty under their NPI or CLIA 4. Current system does not use license status to price and pay claims. We are paying providers who are no longer licensed 5. 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 6. 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 7. Lack of standardization for regular updates to provider information 8. Lack of timeliness
Notes:

Manage Provider Communication – PM02

CO MITA 3.0 SS-A Project

Business Area: Provider Management
Business Category: Provider Support
Business Process: Manage Provider Communication
Author(s): Christina Chavez, Dianne Hinricher, Tim Gaub, Ryan Martin, Marceil Case, Karen Janulewicz, Nicholas Clark, Jerry Smallwood, Laurie Stephens, Colleen Daywalt, Cathy Fielder, Alex Stephens, Evan Grimes
Facilitator: Nicole Wong
Actor(s): Fiscal Agent, Department Staff, Providers, Stakeholders (advocates, clients, public, legislative representatives, etc.), Contractors
MITA 3.0 Business Process Description: The **Manage Provider Communication** business process receives requests for information, provides publications, and assistance from prospective and current providers' communications (e.g., inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements). The State Medicaid Agency (SMA) may communicate information using a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). This business process includes the log, research, development, approval and delivery of routine or ad hoc messages. **NOTE**: **Manage Provider Communication** business process handles inquiry from prospective and current providers by providing assistance and responses to individual entities (i.e., bi-directional communication). Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The **Perform Provider Outreach (PM3)** business process (part of the Provider Management business area) targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues. ***CO Business Process Description:*** Colorado's **Manage Provider Communication** business process is generally aligned with the MITA 3.0 Framework.
Precondition: • Enrolled providers • Prospective providers

Manage Provider Communication – PM02

***Trigger(s)*:**
1. Program changes (rates, forms, etc.)
2. Support and education
3. Notifications of non-payment (from COFRS/CORE)
4. PARs
5. Notification of termination for no claims
6. Audit findings on providers

Manual (M) or Automated (A)		***Steps:***
		Alternate Sequence: Received by Fiscal Agent
1.	M	**START**: **Receive** output of trigger
2.	M	If received by Fiscal Agent, Fiscal Agent **contacts** Claims Systems and Operations regarding need
3.	M	Claims Systems and Operations **takes** need to Policy Section and **agree** upon solution
4.	M	**END: Distribute** information
		Alternate Sequence: Received by Policy Section
5.	M	**START: Receive** output of trigger
6.	M	If received by Policy Section, **make** decision
7.	M	**END: Distribute** information
		Alternate Sequence: Received by Claims Systems and Operations
8.	M	**START: Receive** output of trigger
9.	M	If received by Claims Systems and Operations, **take** need to Policy Section and **agree** upon solution
10.	M	**END: Distribute** information
		Alternate Sequence: Finding Identified by Audit
11.	M	**START: Receive** output of trigger
12.	M	If finding identified by Audit, **determine** appropriate action
13.	M	**END: Distribute** information

***Outcome*:**
1. Appropriate information is communicated to providers

As Is Performance Metrics:	***To Be Performance Metrics:***
• Controlled correspondence is monitored and tracked • Acknowledgement within 48 hours ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• Accuracy of communications = ensure program and benefit is set up appropriately to communicate in a timely manner

Manage Provider Communication – PM02

Shared Data/Interfaces, Inbound: 1. Web portal 2. Website 3. MMIS 4. Email 5. Phone Calls 6. Mail 7. Face-to-face/Meetings	***Shared Data/Interfaces, Outbound*:** 1. Email 2. Website 3. Web portal 4. Mail 5. DSS 6. PCR 7. Phone calls
To Be Future Vision: 1. Support multiple provider email addresses 2. Email address verification/validation 3. Ability to unsubscribe 4. Logging and tracking of communications 5. Targeted communications (audience, provider community types, and timing) 6. Filtered search capabilities 7. Return receipt capabilities 8. Provider subscription options 9. Require providers to update / confirm address and other contact information within 30 days of the change via web portal 10. IM and texting capabilities 11. Mobile applications 12. More flexibility in customizing communications	
Failures of the Current Process: 1. System limitations 2. Limited ability to customize communications 3. Outdated email system 4. Contract limitations 5. Incorrect provider contact information	
Notes:	

CO MITA 3.0 SS-A Project

Business Area: Provider Management
Business Category: Provider Support
Business Process: Perform Provider Outreach
Author(s): Christina Chavez, Dianne Hinricher, Tim Gaub, Ryan Martin, Marceil Case, Karen Janulewicz, Nicholas Clark, Jerry Smallwood, Laurie Stephens, Colleen Daywalt, Cathy Fielder, Alex Stephens, Evan Grimes
Facilitator: Nicole Wong
Actor(s): Fiscal Agent, Department Staff, Providers, Contractors, Clients, Federal and State Agencies, Stakeholders (advocates, clients, public, legislative representatives, etc.)
MITA 3.0 Business Process Description: The **Perform Provider Outreach** business process originates internally within the State Medicaid Agency (SMA) in response to multiple activities (e.g., identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, modifications in the Medicaid Program policies and procedures). SMA may develop prospective Provider outreach information, also referred to as Provider Recruiting information, for targeted providers identified by analyzing program information (for example, not enough dentists to serve a population, new immigrants need language-compatible providers). Enrolled Provider outreach information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives. The State Medicaid Agency develops outreach information for target populations identified by analyzing member information. The State Medicaid Agency may communicate information in a variety of methods such as email, mail, publication, mobile device, facsimile, telephone, web or Electronic Data Interchange (EDI). The State Medicaid Agency produces, distributes, tracks and archives all contractor outreach communications according to state rules. The **Manage Performance Measures (PL05)** business process (part of the Plan Management business area) defines benchmarks and measures outreach efficacy. **NOTE**: The **Perform Provider Outreach** business process targets both prospective and current provider populations for distribution of information about programs, policies, and health issues. **Manage Provider Communication (PM02)** business process (part of the Provider Management business area) handles inquiry from applicants, prospective and current providers by providing assistance and responses to individuals (i.e., bi-directional

communication).

CO Business Process Description:
Colorado's **Perform Provider Outreach** business process is generally aligned with the MITA 3.0 Framework.

Precondition:
- Prospective or enrolled providers

***Trigger(s)*:**
Scenarios include:
1. Not enough providers to serve a population or specialty population
2. Corrections in billing practices
3. Provider complaints
4. Public health alerts
5. Public service announcements
6. Retention efforts
7. Changes in the Medicaid program policies and procedures
8. Rolling out a new program
9. Stakeholder engagement efforts for a new program and implementation planning

Manual (M) or Automated (A)		***Steps:***
		Provider Recruitment
1.	M	**START**: **Conduct** gap analysis
2.	M	**Identify** prospective providers
3.	M	**Contact** prospective providers
4.	M	**Send** enrollment/marketing information to prospective providers
5.	M	**Assist** with enrollment if requested
6.	M	**END: Trigger Determine Provider Eligibility (EE05)** business process (part of the Eligibility and Enrollment business area)
		Alternate Sequence: Provider Retention
1.	M	**START**: **Identify** providers
2.	M	**Contact** providers
3.	M	**Send** information to providers regarding enhancements, incentives, removal of barriers to continued participation, reimbursement, etc.
4.	M	**Assist** with changes to provider services
5.	M	**END: Retain** providers
		Alternate Sequence: Regular Provider Communications
1.	M	**START: Trigger** received
2.	M	**Identify** provider populations affected
3.	M	**Craft** outbound message
4.	M	**END: Send** information to providers

***Outcome*:**

<table>
<tr><td colspan="2">1. Providers are enrolled/retained
2. Providers are informed</td></tr>
<tr><td>As Is Performance Metrics:
• Effectiveness of the communication – Outreach results in achieving specified goals (e.g., recruitment of new providers from targeted population)
• 30 days notice for billing changes

Supporting Performance Metrics/SLA Documentation:
• N/A</td><td>To Be Performance Metrics:
• Measure understanding and effectiveness of communications
• Penetration rate
• Develop Management Report for Provider Participation similar to those currently in place for many of the HPSS programs and benefits. This report would be updated at least quarterly and include Medicaid enrollment, ACC enrollment, hot topics, etc.</td></tr>
<tr><td>Shared Data/Interfaces, Inbound:
1. DORA
2. MMIS
3. CDPHE
4. NPPES
5. CMS
6. Email
7. Phone Call
8. Face-to-face meeting
9. Mail</td><td>Shared Data/Interfaces, Outbound:
1. Website
2. Web Portal
3. Email
4. PCR
5. Mail
6. Provider Training
7. Newsletters
8. Webinars
9. DSS
10. Phone Calls
11. Face-to-face meeting</td></tr>
<tr><td colspan="2">To Be Future Vision:
1. 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 do wild card searches for all searchable fields, including searches with partial ID numbers, etc.</td></tr>
</table>

2. Proactively identifing 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 3. Increased automation 4. Functionality of new systems 5. Mechanisms for feedback 6. Develop Management Report for Provider Participation similar to those currently in place for many of the HPSS programs and benefits. This report would be updated at least quarterly and include Medicaid enrollment, ACC enrollment, hot topics, etc.
Failures of the Current Process: 1. Lack of new processes 2. Manual process 3. Not dynamic 4. Disorganized internal communication 5. Unreliable accuracy of communication 6. Timeliness 7. Lack of access to communications 8. Reliance on mail (cost and timeliness issues) 9. Antiquated methods of communication
Notes:

CO MITA 3.0 SS-A Project

Business Area: Provider Management
Business Category: Provider Support
Business Process: Manage Provider Grievance and Appeal
Author(s): Cathy Fielder, Marty Janssen, Nicholas Clark, Laurie Stephens, Karen Janulewicz, Ryan Martin, Marceil Case, Alex Stephens, Jeremy Oat, Kim Nguyen, Dianne Hinricher
Other Attendance (non-participating): Karl Schnur
Facilitator: Nicole Wong
Actor(s): Providers, Department Staff, Attorney General's Office (AG), Office of Administrative Courts (OAC), Contractors, Fiscal Agent, Other State Agencies
MITA 3.0 Business Process Description: The **Manage Provider Grievance and Appeal** business process handles provider* appeals of adverse decisions or communications of a grievance. The **Manage Provider Communication** business process (PM02 - part of the Provider Management business area) initiates a grievance or appeal from a provider. The State Medicaid Agency (SMA) logs and tracks the grievance or appeal, triages it, and sends it to appropriate reviewers. Staff researches or requests additional information. The SMA may schedule a hearing, conduct actions in accordance with legal requirements, and make a ruling based upon the evidence presented. Staff documents and distributes results of the hearings, and adds relevant documents to the provider's information. SMA formally notifies provider of the decision. This business process supports the **Manage Performance Measures (PL05)** business process (part of the Plan Management business area) by providing information about the types of grievances and appeals it handles, grievance and appeals issues, parties that file or are the target of the grievances and appeals, and the dispositions. The SMA uses information to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals. Based on the appeal business process, if a provider wins an appeal that affects or clarifies a Medicaid State Plan, health plan, or health benefit, this process sends that information to **Maintain State Plan (PL03)** (part of the Plan Management business area), **Manage Health Plan Information (PL04)** (part of the Plan Management business area), or **Manage Health Benefit Information (PL06)** business processes (part of the Plan Management business area) to modify the relevant policy or procedure. Disposition could result in legislative change requirements that the SMA will communicate to lawmakers. **NOTE**: States may define grievance and appeal differently, depending on state laws. States

may involve multiple agencies in the **Manage Provider Grievance and Appeal** business process.

*This business process supports grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a grievance or appeal, for example, when SMA denies an application for enrollment.

CO Business Process Description:
Colorado's **Manage Provider Grievance and Appeal** business process is generally aligned with the MITA 3.0 Framework. In Colorado's process, results of the hearing are documented and relevant documents are distributed to the provider file. It does not reference modifications to the relevant policy or procedure as a result of winning an appeal.

Precondition:

- Enrolled or pending provider enrollment or termed or denied providers

***Trigger(s)*:**

1. Adverse action has occurred (denied enrollment, denied payment, terminated enrollment, recovery of overpayments, etc.)

Manual (M) or Automated (A)		***Steps:***
1.	M	**START**: Provider **submits** written provider appeal to Office of Administrative Courts (OAC) within required time (OAC conducts hearings for the department)
2.	M	**OAC forwards** written appeal request to AG's office
3.	M/A	AG's office **notifies** Department about receipt of appeal
4.	M	Department **conducts** research on the reported issue and **provides** documentation and information to the AG's office
5.	M	Department **provides** position statement to the AG's office
6.	M	AG **conducts** court required settlement conference with provider and Department
7.	M	Department **determines** its position on the appeal and communicates to the AG's office.
8.	M	AG **conducts** further settlement negotiations, **requests** dismissal of appeal if Department agrees with provider position, or **represents** the Department at the hearing
9.	M	Settlement agreement is **executed**, AG requests dismissal of appeal, or OAC **conducts** hearing if necessary
10.	M	Provider and Department **receive** notification of decision
11.	M	**END:** If provider loses appeal or settles, provider **agrees** to perform actions and Department **conducts** follow up
12.	M	**END:** If Department **agrees** with appeal or loses appeal policy staff is

		notified of program vulnerability

Outcome:
1. Resolution of appeal

As Is Performance Metrics:	***To Be Performance Metrics:***
• Comply with CRS 25.5-4-301 • Comply with 10 CCR 2505-10, section 8.050 • Comply with Office of Administrative Court rules ***Supporting Performance Metrics/SLA Documentation:*** • Comply with CRS 25.5-4-301 • Comply with 10 CCR 2505-10, section 8.050 • Comply with Office of Administrative Court rules	• Same as As-Is
Shared Data/Interfaces, Inbound: 1. DORA 2. NPPES 3. ASPEN 4. MMIS 5. DSS 6. Email 7. Phone calls 8. Regular mail 9. AG's office	***Shared Data/Interfaces, Outbound***: 1. Email 2. Phone calls 3. Regular mail 4. AG's office

To Be Future Vision:
1. Capabilities to track appeals communication, notifications, etc.
2. Improved interface with DORA
3. Comprehensive database of nation-wide provider information
4. Ability to access correct information (rule, address, etc.)

Failures of the Current Process:
1. Incorrect regulation(s)
2. Too many players
3. Researching proper Rules updates is time consuming

Notes:

Terminate Provider – PM08

CO MITA 3.0 SS-A Project

Business Area: Provider Management
Business Category: Provider Information Management
Business Process: Terminate Provider
Author(s): Cathy Fielder, Marty Janssen, Nicholas Clark, Laurie Stephens, Karen Janulewicz, Ryan Martin, Marceil Case, Alex Stephens, Jeremy Oat, Kim Nguyen, Dianne Hinricher
Other Attendance (non-participating): Karl Schnur
Facilitator: Nicole Wong
Actor(s): Providers, Department Staff, Other State Agencies, Fiscal Agent, CMS, HHS OIG, Licensing Boards, Other Federal Agencies

MITA 3.0 Business Process Description:

The **Terminate Provider** business process is responsible for the termination of provider agreement to participate in the Medicaid Program. The basis for termination can be:

- Centers for Medicare & Medicaid Services (CMS) and the State Medicaid Agency (SMA) terminate a provider agreement if an individual provider:
  - Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or
  - Provider does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1).
- CMS and the state may terminate a facility's provider agreement if a facility:
  - Is not in substantial compliance with the requirements of participation, regardless of whether immediate jeopardy is present; or
  - Facility fails to submit an acceptable Corrective Action Plan (CAP) within the timeframe specified by CMS or the SMA.
- CMS and the SMA terminate a facility's provider agreement if a facility:
  - Fails to relinquish control to the temporary manager, if CMS or the SMA imposes that remedy; or
  - Facility does not meet the eligibility criteria for continuation of payment as set forth in 42 CFR 488.412(a)(1).

The effect of termination of the provider agreement ends: (1) payment to the facility, and (2) any alternative remedy.

CO Business Process Description:

Colorado's **Terminate Provider** business process generally aligns with MITA 3.0. There are additional basis for termination in Colorado rules. There are additional bases for termination in Colorado rules.

Terminate Provider – PM08

Note: CMS can direct SMA to terminate a provider agreeement; however, CMS is not able to execute a provider termination. Termination of provider agreement does not end any alternative remedy.

Precondition:

- Enrolled provider

***Trigger(s)*:**

1. Receive alert to cease activities with provider
2. Receive request to terminate provider
3. Receive notification of termination of provider from data sources

Manual (M) or Automated (A)		***Steps:***
1.	M/A	**START**: **Receive** alert, notification, or request to terminate provider
2.	M/A	Department **reviews** request and **investigates** to determine whether provider agreement should be terminated
3.	M	**End: Trigger Determine Adverse Action Incident (PE04)** business process
4.	M	**End: Termination** not required. No or other action as required
5.	M	**Send** alert to notify Health Insurance Exchange (HIX) of provider termination information
6.	M	**END: Notify** fiscal agent to implement the termination of provider from participation in Medicaid Program

***Outcome*:**

1. Termination of provider from participation in Medicaid Program, and trigger to **Determine Adverse Action Incident (PE04)** business process
2. Alert sent to notify Health Insurance Exchange (HIX) of provider termination information
3. Alert sent to notify insurance affordability program of provider termination information
4. Tracking information as needed for measuring performance and business activity monitoring
5. No further action required

As Is Performance Metrics:

- Compliance with Colorado rules referenced in description

Supporting Performance Metrics/SLA Documentation:

- N/A

To Be Performance Metrics:

- Same as As-Is

Shared Data/Interfaces, Inbound:

1. MMIS
2. CDPHE
3. ASPEN
4. DORA

***Shared Data/Interfaces, Outbound*:**

1. MMIS
2. Trackwise
3. Email

5. Data sources (e.g. federal data bases of excluded providers) 6. Compliance Management data store including compliance incident information	4. Phone calls 5. Regular mail 6. CMS termination notification system 7. HHS OIG 8. Department Website
To Be Future Vision: 1.	
Failures of the Current Process: 1. Unable to find requested Provider 2. Identifying information on provider is not available for inquiry	
Notes:	

11 – Outlier Use Cases

The following use cases describe business processes that Colorado does not perform. The content of these use cases was populated directly from the Centers for Medicare and Medicaid Services MITA 3.0 material. Colorado does not perform OM20 – Calculate Spend-down Amount. The activities of PE02 – Establish Compliance Incident are performed in PE01 – Identify Utilization Anomalies. Because Colorado does not perform these processes, there are no scorecards to accompany these use cases.

Calculate Spend-down Amount – OM20

CO MITA 3.0 SS-A Project

Business Area: Operations Management
Business Category: Claims Adjudication
Business Process: Calculate Spend-down Amount
Author(s): Bailey Perkins, Sandy Salus, Tim Gaub, Vernae Roquemore; Carol Reinboldt
Other Attendance (non-participating): Karl Schnur (Sellers Dorsey), Mark Schaffer (Sellers Dorsey)
Facilitator: Nicole Wong
Actor(s): N/A
MITA 3.0 Business Process Description: A person that is not eligible for medical coverage when they have income above the health plan standards may become eligible for coverage through a process called spend-down (see **Determine Member Eligibility (EE01)** business process (part of the Eligibility and Enrollment Management business area)). The **Calculate Spend-Down Amount** business process is responsible for tracking spend-down amounts and determining if a member meets its responsibility through the submission of medical claims. The **Process Claim (OM07)** business process (part of the Operations Management business area) automatically accounts for the spend-down amount during adjudication. Once the member has met the spend-down obligation, a modification of eligibility status allows Medicaid payments to begin and/or resume. This typically occurs in situations where a member has a chronic condition and is consistently above the resource levels, but it may also occur in other situations. The **Calculate Spend-Down Amount** business process begins with the receipt of member's health plan information from **Enroll Member (EE02)** business process (part of the Eligibility and Enrollment Management business area) that requires a predetermined amount the member will be financially responsible for prior to Medicaid payment for any medical services. ***CO Business Process Description:*** Colorado does not perform this business process.
Precondition: • **Enroll Member (EE02)** (part of the Eligibility and Enrollment Management business area) • **Process Claim (OM07)** (part of the Operations Management business area)
Trigger(s): 1. Receive health plan information from **Enroll Member (EE02)** business process (part of the Eligibility and Enrollment Management business area)

Calculate Spend-down Amount – OM20

Manual (M) or Automated (A)		*Steps:*
1.		**START**: **Receive** health plan information from **Enroll Member (EE01)** business process (part of the Eligibility and Enrollment Management business area).
2.		**Determine** spend-down obligation amount
3.		**Receive** claim including payment information
4.		**Subtract** medical claim amounts from member's spend-down until they meet their responsibility
5.		**Send** alert to **Manage Member Information (ME01)** business process (part of the Member Management business area) with spend-down information
6.		**END**: **Send** notification that member has met spend-down obligation via **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area).

Outcome:

1. Member has met spend-down obligation
2. Alert sent to **Manage Member Information (ME01)** business process (part of the Member Management business area) with spend-down information
3. Sent notification that Member has met spend-down obligation to member via **Manage Applicant and Member Communication (ME02)** business process (part of the Member Management business area)
4. Tracking information as needed for measuring performance and business activity monitoring

As Is Performance Metrics:	*To Be Performance Metrics:*
• N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	• N/A
Shared Data/Interfaces, Inbound: 1. N/A	***Shared Data/Interfaces, Outbound***: 1. N/A

To Be Future Vision:

1.

Failures of the Current Process:

1. No health plan information from the **Enroll Member (EE01)** business process (part of the Eligibility and Enrollment Management business area)

Notes:

Calculate Spend-down Amount – OM20

Establish Compliance Incident – PE02

CO MITA 3.0 SS-A Project

Business Area: Performance Management (PE)

Business Category: Compliance Management

Business Process: Establish Compliance Incident

Author(s): N/A

Facilitator: N/A

Actor(s): N/A

MITA 3.0 Business Process Description:
The **Establish Compliance Incident** business process is responsible registration of a case for incident tracking of utilization anomalies. It establishes an incident file, generates incident identification, assigns an incident manager, links to related cases, and collects related documentation.

CO Business Process Description:
Colorado does not perform the functions of the **Establish Compliance Incident** business process separately from the **Identify Utilization Anomalies (PE01)** business process (part of the Performance Management business area). The functions of this business process can be found in **Identify Utilization Anomalies (PE01)** (part of the Performance Management business area).

Precondition:

- **Identify Utilization Anomalies (PE01)** (part of the Performance Management business area)
- **Manage Member Information (ME01)** (part of the Member Management business area)
- **Manage Provider Information (PM01)** (part of the Provider Management business area)
- **Manage Contractor Information (CO01)** (part of the Contractor Management business area)

Trigger(s):
Incident-based Trigger Events:

1. Receive alert to establish incident tracking from **Identify Utilization Anomalies (PE01)** business process (part of the Performance Management business area)
2. Receive alert to establish incident tracking from **Manage Member Grievance and Appeal (ME08)** business process (part of the Member Management business area)
3. Receive alert to establish incident tracking from **Manage Provider Grievance and Appeal (PM07)** business process (part of the Provider Management business area)

Establish Compliance Incident – PE02

4. Receive alert to establish incident tracking from **Manage Contractor Grievance and Appeal (CO09)** business process (part of the Contractor Management business area).

Environment-based Trigger Events:
1. Request to initiate incident tracking for business partner, member, provider, contractor or other entity
2. Request to initiate incident from communication (e.g., mail, telephone, facsimile or web)
3. Receive requests for suppression of information or corrective action from federal and state law enforcement
4. Receive compliance investigation information from Centers for Medicare & Medicaid Services (CMS)
5. Receive compliance investigation information from Medicaid Fraud Control Unit (MFCU)
6. Receive compliance investigation information from Office of Inspector General (OIG)
7. Receive self-disclosure of actual or potential violations from provider

Manual (M) or Automated (A)		***Steps:***
1.		**START**: **Request** to establish incident tracking
2.		**Establish** incident case with required information
3.		**Generate** incident identification
4.		**Assign** and **authorize** an incident manager to **manage** an incident and **request** additional information
5.		**Identify** and **link** related incidents to this one
6.		**Collect** relevant documentation
7.		If applicable, **send** notification to state or federal law enforcement agencies of possible criminal investigation
8.		If applicable, **send** notification to CMS of compliance investigation
9.		If applicable, **send** notification to MFCU of compliance investigation
10.		If applicable, **send** notification to OIG of compliance investigation
11.		**END: Send** alert to **Manage Compliance Incident Information (PE03)** business process (part of the Performance Management business area) for incident monitoring

Outcome:
1. Initiation of a compliance incident
2. Alert sent to **Manage Compliance Incident Information (PE03)** business process (part of the Performance Management business area) for incident monitoring
3. If applicable, notification sent to state or federal law enforcement agencies of possible criminal investigation
4. If applicable, notification sent to CMS of compliance investigation
5. If applicable, notification sent to MFCU of compliance investigation

Establish Compliance Incident – PE02

6. If applicable, notification sent to OIG of compliance investigation 7. Tracking information as needed for measuring performance and business activity monitoring.	
As Is Performance Metrics: • N/A ***Supporting Performance Metrics/SLA Documentation:*** • N/A	***To Be Performance Metrics:*** • N/A
Shared Data/Interfaces, Inbound: 1. Member data store including demographics, eligibility, enrollment, and grievance information 2. Provider data store including provider network, contract, and grievance information 3. Contractor data store including provider network, and contract grievance information 4. Claims data store including payment information 5. Financial data store including accounts receivable and accounts payable information 6. Business Activity data store including performance information 7. Compliance Management data store including compliance incident information	***Shared Data/Interfaces, Outbound***: 1.
To Be Future Vision: 1. Manage Compliance Incident Information	
Failures of the Current Process: 1. No incident tracking requests made 2. Lack of required information to establish an incident	
Notes:	

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